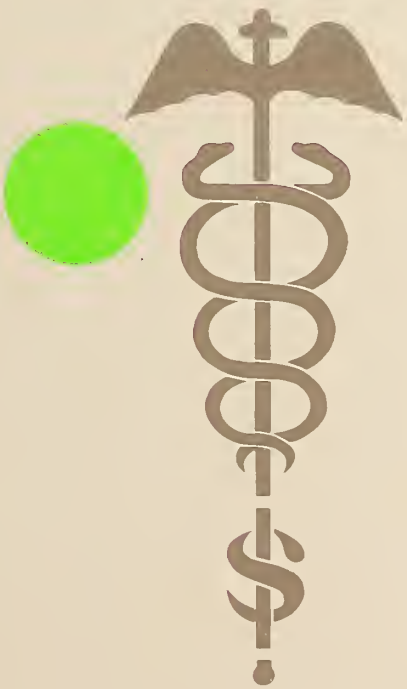
State Initiatives in Medicaid Cost Containment



Center for Policy Research
Office of Research Studies
National Governors' Association

In response to requests from Governors for information to assist them in curbing health care costs, the National Governors' Association Center for Policy Research, Office of Research Studies conducted a survey of cost containment strategies currently in use or proposed in each state. The questionnaire was designed to gather information on state strategies for containing health care costs through changes in law, regulation, program administration and demonstration projects. The survey results are compiled in two documents, one dealing with with state Medicaid initiatives, and the second dealing with other state health progams. A third publication, detailing state options for Medicaid cost containment, was also prepared as part of the Center's project. Partial support for the activities was provided by the Health Care Financing Administration under Grant #18-P-7490/3-01. We would like to give special thanks to Dorrett Lyttle, Janice Webb, John Steel, Kathleen Sullivan, Kendra Mahoney, Virender Manocha and Beverly Smith for their significant contributions to the data collections and analysis, and preparation of the project publications. Appreciation is also due to Jan Kary for coordinating the national conferences.

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Introduction

The National Governors' Association State Initiatives in Medicaid Cost Containment is a companion document to the State Guide to Medicaid Cost Containment. The Guide sets forth six basic strategies the states can pursue to control Medicaid expenditures short of reducing eligible recipients or eliminating services. They include:

- o minimizing or eliminating the use of open ended and/or provider controlled reimbursement for nursing homes, hospitals,and physicians;
- o minimizing provider and recipient misuse of the program;
- o restructuring program coverage so that care is delivered in an appropriate but least expensive setting;
- o minimizing eligibility errors;
- o minimizing Medicaid's subsidy of other third parties; and
- o maximizing the purchasing power of the state.

This companion paper examines each state's use of the same cost control tools. The information reported in the abstracts which follow was provided by Medicaid Directors and their staffs in response to an extensive Health Care Cost Containment survey of the states. Their cooperation was vital to the project. Forty-five of the forth-nine state programs are described.

Summary

In these particularly difficult economic times, the need for medical assistance increases while state resources decrease. The assumption, however, that states are reducing eligibility standards and benefits in response to economic pressure appears unfounded. Between 1978 and the late summer 1980, the majority of Medicaid program changes reported by the states increased both coverage and eligibility. However, given continued growth in fiscal stress, states may have implemented cutbacks in Medicaid this fall.

Of the strategies examined, state activity has been the greatest in three areas: controlling reimbursement to hospitals and nursing homes (substantially less so for physicians); improving utilization controls; and, minimizing eligibility errors. The tables below summarize state activity in each of the areas.

TABLE ONE

HOSPITAL REIMBURSEMENT

PROGRAM FEATURE	ADOPTED	PROPOSED
1. Alternative Definition of "Reasonable Cost"	10	2
2. Imputing an Occupancy Rate	6	1
3. Denial of Reimbursement for Percentage Contracts	3	3
4. Limiting Laboratory Reimbursement to High Volume Automated Rate	3	2
5. Denial of Reimbursement for Nonemergency Weekend Admissions	12	2
6. Limiting Reimbursement to Rate of the Least Expensive Setting	9	1
7. Common Medicare and Medicaid Audits	40	2
8. Tape-To-Tape Billing	19	16
9. Limiting Age of Claims	43	0

TABLE TWO

NURSING HOME REIMBURSEMENT

PROGRAM FEATURE	ADOPTED	PROPOSED
1. Eliminating of Profit Factor in Reimbursement Rate	8	0
2. Establishment of Rate Ceilings	37	0
3. Reimbursement According to Peer Grouping	20	0
4. Limiting Capital Costs	25	3
5. Elimination of Efficiency Incentives	4	0
6. Tying Reimbursement Rates to Grades of Patient Disability	12	2
7. Submission of Single Invoice by Nursing Home for all Patients	26	4
8. Limiting Pass Throughs	11	1
9. Setting Limits by Cost Centers i.e., Nursing, Dietary, etc.	24	3
10. Indexing Reimbursement Rate to Economic Trend Factors	35	1
11. Caps on Administrative Salaries	35	2
12. Imputing a useful life-time of 40 years on Nursing Home Facilities	19	0
13. Identical Treatment of Leased and Owned Facilities	23	2

TABLE THREE

UTILIZATION CONTROLS*

PROGRAM FEATURE	ADOPTED	PROPOSED
1. Monitoring Hospital Discharge Planning Units	12	4
2. Disallowance of Claims	36	0
3. Limitation on Length of Stay for Stays Without PSRO Approval	24	1
4. Require Participating Providers to Provide Access to Medical Records	44	0
5. Changing Coverage or Reimbursement Rate for Administrative Days	8	0
6. Requiring Identification of Ordering Physician on Laboratory, X-ray, and Prescription claims	35	2
7. Patient Education	15	1
8. Lock-in of High Users to One Physician	29	3
9. Provider Education	33	0

* A discussion of prior authorization and client-screening programs is included in each state abstract.

TABLE FOUR

MINIMIZING ELIGIBILITY ERRORS

PROGRAM FEATURE	ADOPTED	PROPOSED
1. Error Prone Profiling	8	11
2. Consolidation of Welfare and Medicaid Eligibility Applications	28	1
3. Retreival of Medicaid ID Cards from Ineligibles	22	1
4. Training Eligibility Determination Workers	39	2
5. Monitoring Eligibility Determination Workers Performance	34	3
6. Monitoring of Client Income Through Linkages with other Employment Data Files	29	5
7. Monthly Client Status Report	19	3
8. Provider Vertification of Client Identification	23	1
9. Provider Telephone Inquiries to State as to Eligibility Status	27	1
10. Personal Pick-up of Checks	6	0
11. Photo ID	10	1

ABSTRACTS

Measures implemented to control administrative errors or costs in eligibility determination in 1974 included training of eligibility determination workers and monitoring of their performance. Error pone profiling has been proposed. To reduce client errors in eligibility, monitoring of client income through linkage with other employment data files was adopted in 1978 and beginning in 1980, monthly client status reports and photo ID are required. Provider verification of client identification has been proposed in addition to MEQC error profiles.

As of 1970, the state has implemented a program to recover Medicaid funds from the Veteran's Administration, health and casualty insurance, and absent parents beginning in 1979, and through federal financial participation in retroactive Medicaid eligibility determination.

Numberous changes were made in Medicaid covered services in 1980, beginning with a reduction in drug formulary to eliminate cough and cold preparations saving $500,000 annually. Hospital inpatient days were reduced from 30 days per year to 15 days with up to 5 days extension if medically necessary, a reduction which is expected to save $3.75 million per year. Outpatient hospital visits were also reduced to 6 per year unless prior authorized, saving $1.3 million annually. The exceptions to this limit are emergencies, chemotherapy, radiation therapy, hemodialysis and hemophilia. Out of state services were limited to emergencies unless prior authorized, saving $200,000, and unlimited hospital days for those under 21 years old are permitted only for conditions discovered during screening, which it estimated to save $1 million. Lastly, Friday and Saturday hospital admissions are denied unless medically necessary and presurgical admissions limited to one day unless medically necessary. A total of $1.5 million is expected to be saved annually from this limit.

Mandatory Medicaid benefits for inpatient hospital services rose 57.73 percent from 1978 to 1979, from $48.028 million to $73.353, and in the first seven months of Fiscal Year 1980 totaled $33.681 million. Funds for outpatient hospital services and rural health clinics also increased by 48.32 percent from 1978 to 1979, from $5.451 million to $8.085 million, and reached $6.312 million in the first seven months of Fiscal Year 1980. Physician services increased from $19.065 million in 1978 to $20.305 million in 1979, and reached $19.095 million during the first seven months in 1980. SNF care, which grew from 45.659 million to $64.236 million in 1978 to 1979, reached $22.532 million in the first seven months of Fiscal Year 1980. Lab and x-ray funds declined from 1978 to 1979 from $4.698 million to $3.860 million, family planning increased from $759,335 to $1.308 million and early and periodic screening and diagnostic testing from $1.029 to $1.157 million over the same period.

Optional benefits such as home health care also increased from 1978 to 1979, from $1.240 million to $1.979 million, and dental care from $3.468 million to $4.219 million. The largest optional expenditures were for drugs and ICF care which grew 24.2 percent and 331.16 percent respectively from 1978 to 1979. Drug funds increased from $17.939 million to $22.277 million and ICF funds from $44.127 million to $58.759 million.

The state's hospital reimbursement system adopted disallowance of weekend admission rembursement for non-emergency surgery in 1979. The reimbursement system pays all hospitals on an interim basis and conducts common Medicare and Medicaid audits as of 1970. A limit on the age of claims and denial of reimbursement for the 8.5 percent nursing cost differential was also adopted in 1970. The nursing home system placed caps on administrative salaries in 1974, established rate ceilings and placed limits on capital costs in 1976, and implemented reimbursement according to peer grouping in 1977. Other measures which have been adopted include elimination of a profit factor in the reimbursement rate, submission of single invoices by nursing homes for all patients, setting limits by cost centers for administrative salaries and consultants, and indexing reimbursement rates to economic trend factors.

Physician services are reimbursed on the basis of usual, customary and reasonable charges. They are reimbursed at the lesser of: 1) an individual profile which has been unchanged since 1975 except in extraordinary circumstances; or, 2) area prevailing usual reasonable and customary charge at 75 percent for specialty. If neither option 1 or 2 fits, a statewide average is used. As of 1970, reimbursement is at the rate for service when it was delivered, not billed and at the rate where service was delivered, not from where service is billed. In 1980 legislation was passed to place a $2 copayment on a physician visit, although this is being challenged in federal court.

During 1980 Medicaid reimbursement rates and copayments were changed. Drug copayments were raised to the maximum allowed by Federal regulations, 50 cents for charges less than $11, $1 for changes from $11 to $25.99, $2 for changes from $26 to $50.99 and $3 for any charge over $51, for an estimated savings of $85,000. A $2 copayment was required for physicians and other medical practitioners for an estimated savings of $3.1 million; however a federal suit has resulted in a temporary injunction. Nursing home patient' resources, now paid to the county tax collector are forwarded to Medicaid for use in matching FFP. Nursing homes are paid a full per diem. The legislation has passed and is under implementation, but the federal government may deny matching funds. At present a suit is in federal court. This change would have meant a change in expenditure of $23 million. Rural health clinics are paid the lesser of the encounter fee or charges, saving $23,000 annually.

Prior authorization is needed for non-emergency out of state medical care, for drugs not listed in the Alabama Drug Code Index, and for extra eyeglasses. All home health care is prior authorized and nursing home admissions preassessed. Second opinions are a voluntary effort in effect for one year, during which time there have been only 60 inquiries. All prior authorizations have been in effect for several years.

Utilization control measures have been adopted since 1957 beginning with limitations on the length of stays for stays without PSRO approval. In 1970, the disallowance of claims, the requirement that participating providers provide acess to medical records and provider education were implemented. Lock in of high users to one physician was adopted in 1974, and required identification of the ordering physician on laboratory, x-ray and prescription claims in 1978.

In 1970 the state began to contract out to a fiscal intermediary and for provider relations; in 1974 Alabama implemented bulk purchasing of goods. A Medicaid Management Information System was instituted in 1978 and in 1980 the state reassumed maintenance of provider enrollent information.

Total Medicaid expenditures increased from $208.421 million in 1978 to $325.0 million in 1980. The state outlay of funds grew from $58.065 million to $90.0 million, and the federal outlay from $150.356 million, to $235.0 million. Proportionately, the state contributed nearly 28 percent of the total and the federal government approximately 72 percent. The state's outlay of funds increased 55.0 percent from 1978 to 1980 and the federal government's outlay grew by 56.3 percent. The number of categorical eligibles also increased from 403,330 to 410,000 over the same period. Between 1978 and 1979, the average per day hospital room reimbursement rate rose from $117.0 to $131.0, or 11.97 percent. The average nonspecialist physician rate per office visit rose from $13.70 to $13.86, the SNF rate rose from $17.98 to $18.61 and ICF care from $17.09 to $17.85 from 1978 to 1979.

To control administrative errors or costs in eligibility determination, error prone profiling, consolidation of Welfare and Medicaid eligibility applications, training eligibility workers and monitoring their performance were all instituted in 1979. In addition, Medicaid ID cards are valid for one month only, thereby reducing the potential for abuse. Provider vertification of client identification was instituted in 1973 to reduce client errors. In addition, monitoring of client income through linkages with other employment data files was adopted in 1979. Since 1975, the Medicaid program has attempted to recover Medicaid funds from health and casualty insurance and, as of 1980, from absent parents.

In fiscal year 1979, personal care services were added as new program benefits under Medicaid at a cost of $1.4 million, and the stay limit of hospital days increased beyond 26 with PSRO-approval for medically necessary extensions; this measure is expected to cost $3.2 million annually. In 1980, the early and periodic screening for diagnostic testing program was expanded to include dental services. This expansion is expected to cost $220,000 annually.

Mandatory benefits for inpatient hospital services totaled $9.347 million in 1980, increasing only 3.87 percent from 1978 to 1979, but 30.97 percent from 1979 to 1980. Outpatient hospital services and rural health clinics displayed similar increases; from 1978, 1979, expenditures increased from $648,685 to $692,633, or 6.78 percent, but increased 138 percent in 1980 to $1.647 million. Lab and x-ray expenditures declined over the same time period, from $832,883 to $928,434 in 1979 to $80,177 in 1980, perhaps due to the change in reporting procedures which now includes only certified independent labs and x-ray facilities. Funds for SNF increased rapidly from 1978 to 1979, from $3.8 million to $6.9 million or $81.58 percent and rose to $10.2 million, or 47.83 percent, in 1980. Physician services rose from $3.9 million in 1978 to $5.86 million in 1980, or 50.26 percent, and funds for family planning increased almost 500 percent from $16,048 to $95,686. Some optional benefits such as home health care increased from $28,932 in 1978 to $54,367 in 1980, while clinic services decreased from $491,039 to $212,781. Other benefits which grew are dental services which increased from $949,680 to $1.196 million, and drugs which rose from $4.4 million to $5.3 million. ICF benefits declined over the same time period from $23.229 million to $21.881 million.

In 1973 and 1977, the hospital reimbursement system implemented common Medicare and Medicaid audits and a limit on the age of claims. Tape to tape billing has been proposed. During 1978, several measures were adopted by the nursing home reimbursement system including elimination of the profit factor in the reimbursement rate, establishment of rate ceilings, reimbursement according to peer grouping, tying reimbursement rates to grades of patient disability, indexing reimbursement rate to economic trend factors and imputing a useful life of 40 years on nursing home facilities. Proposals to the system include limiting capital costs, submission of single invoices by nursing homes for all patients, setting limits by cost centers and caps on administrative salaries.

Physician services are reimbursed on the basis of usual, customary and reasonable charges. All fees are reviewed annually and updated as

funds allow. Fees for the previous calendar year also are reviewed and the maximim limit is set at 75th percentile of all provider charges for like services. In reimbursing physicians, a limit on the number of billable procedures and reimbursement at the rate for service when it was delivered, not billed, were adopted in 1972 and 1977, respectively.

Medicaid reimbursement rates were changed in 1979 when early and periodic screening and diagnostic testing rates were decreased from $89.43 to $74.56 for an estimated savings of $446,000. The personal care evaluation rate was also reduced from $96 to $63, producing savings of $42,900.

Arkansas currently is proposing to reimburse nurse practitioners and physican assistants indirectly. This provision would apply to reimbursement for PA/NP services in a Rural Health Clinic setting. To date, however, no such services have been instituted in Arkansas.

The state plan for monitoring PSRO utilization review activities is in the final development stage and has not yet been approved for implementation. The monitoring process would be connected with review of quarterly MMIS/SURS reports. The process also reviews hospital performance measurements, including average length of stay per discharge for selected diagnoses and per 1000 Medicaid eligibles, inpatient days per 1000 eligibles and average ancillary charges per discharge. Interagency discussion and arbitration will be used to reduce conflict, with final resolution by HCFA if necessary.

Utilization controls have been adopted between 1970 and 1980 beginning with the requirement that identification of ordering physician be on laboratory, x-ray and prescription claims and that participating providers give access to medical records. Provider education was adopted in 1972 and in 1976 disallowance of claims and limitations on length of stay for stays without PSRO approval was implemented. In 1980, lock in of high users to one physician and patient education were instituted. In 1979 one provider was suspended from the Medicaid program and 12 were fined. In 1980, one provider was removed from the program and 1 sent to jail. Fourten clients were fined in 1979 and 114 in 1980.

To improve Medicaid program administration, bulk purchasing of goods was implemented in 1970, an insured drug program in 1973, and in 1975 utilization of a fiscal agent and implementation of a Medicaid Management Information System.

Medicaid expenditures increased from $174.162 million in 1978 to $224.075 million in 1980. The federal contribution to the total was 72.1 percent in both 1978 and 1979 and 72.87 percent in 1980. The state share was 27.94 percent in 1978, 27.94 percent in 1979, and 27.13 in 1980. Total Medicaid enrollment declined from 264,690 in 1978 to 258,705 in 1979 and rose slightly, in 1980 to 259,278. The decline, however, occured in the number of categorical eligibles, a decrease from 238,928 in 1978 to 231,886 in 1980, while the number of medically needy grew from 25,762 to 27,392. Average per day hospital room reimbursement rates increased from $132 in 1978 to $179 in 1980. Average per day rates for an office visit to a non-specialist physician increased 35.29 percent, from $8.87 in 1978 to $12.0 in 1980. SNF rates grew from $20.34 to $23.35, and ICF rates from $17.68 to $22.45.

During 1979 the cash grant level for the categorically eligible was increased for the SSI/State Supplementy Payment program and the AFDC program. For the medically needy the maintenance levels for AFDC and nondeprived children were increased, as well as for aged, blind and disabled Medically Needy in 1979.

To control administrative errors and costs in eligibility determination, California utilizes a modified error profiling system. The department advises counties of case characteristics which correlate to the most significant and prevalent causes of errors, as demonstrated by Medicaid quality control audits. There is currently no state mandate that counties devote a significant staff efforts to these error prone cases. Individual counties do, however, take special steps to improve accuracy for error prone case types of particular concern to that county. California also has a modified version of Welfare/Medicaid consolidated eligibility applications. The form requesting cash grant is the same as the form that requests only Medicaid. However, the case grant "state of applicant circumstances" form is different from the Medicaid only statement of circumstances form. Medicaid cards for the coming month are issued after the 20th of the current month. As there is a 10 day notice of action period required by federal regulations, clients cannot be discontinued after the 20th, until the end of the following month.

Since the beginning of Medicaid, elibility determination workers have been trained and there is currently a proposal to require each county to follow certain standard internal quality control procedures. A set of procedures are currently being pilot tested in a major county. The department also uses fair hearings decisions to pinpoint trouble areas and counties with a high incidence of county effort in the Medicaid eligibility determination process.

The state also has implemented a simplified Disability Evaluation Referral System, as many counties had failed to refer disabled persons. The new system uses a client health appraisal check list which has resulted in a much higher rate of identification of Medicaidonly disabled cases. To reduce client errors counties are provided with copies of the monthly Bendex file from SSA. A project to assess the cost effectiveness of monitoring earning files currently is being planned. As of 1979 all AFDC linked medically needy and nonlinked Medicaid children are required to complete and return a status report each quarter. Counties are allowed to require month status reports, and a few counties do require them. Medical Quality Control sample case analysis indicates quarterly and monthly status reports by ABDMN's are not cost-effective. Further analysis is being done.

Medicaid has recovered Medicaid funds from Medicare-Part B as of 1966, from health and casualty insurance, provider over payments and beneficiary overpayments before 1971, neo-natal care costs from absent fathers, voluntary payments and through probate as of 1972 and through federal financial participation in retroactive Medicaid eligibility determination as of 1974.

Proposed changes included addition of acupuncture treatment, elimination of sterilizations, (under 21), add ICF/DD habilitative home, and increase of leave days for DD.

Changes in Medicaid covered services include:

Year	Change in Service	Change in Expendiutres
1978	Routine Eye Exams Restricted	$ - 464,400
1979	Added ICFDD	$15,815,000
1978	Added Adult Day Health Care Centers	$ 925,200
	Services by Nonmedical Practitioners at Medical Rate	$ 1,798,500
1978	Added Rural Health Clinics	$ 2,077,300
1978	Added Customized Durable Medical Equipment (For DD Residents in long term care only)	$ 500,000
1978	Restricted drug access for high users	$ -1,440,000
1979	Dental/Vision/Hearing Replacements	$ 743,100
1979	Skilled In-home Services	$ 259,500
1978-1980	Drug Formulary Changes	$ -5,357,500
1980	Added Orthopedic Shoes	$ 414,200

From FY 1977-1978 to FY 1978-1979 Medi-Cal expenditures for physicians grew from $454.203 million to $504.527 million, for drugs from $156.228 million to $174.552 million, for SNF from $486.33 to $568.290 million and for home health from $2.595 million to $2.875 million.

California has received approval for an alternative hospital reimbursement system for inpatient services provided to Medi-Cal recipients. Under the plan reimbursement will be the lessor of each hospitals customary charges, allowable costs determined in accordance with Medicare principles, or an ill-inclusive rate per discharge. This all-inclusive rate per discharge will be retrospectively established for each hospital. The rate per discharge will apply to all covered services provided by the hospital during its final settlement year.

A hospital cost index will be established for each hospital. This index will consist of an input price index and an allowance for changes in service intensity.

After the cost of each hospital's accounting year, the hospital cost index will be calculated to account for actual changes in the input price

index. The hospital cost index will be applied on a commulative basis to the hospital's rate per discharge for the base year to determine its rate per discharge for the final settlement year.

The hospital specific, all-inclusive rater per Medi-Cal discharge, which when multipled by the number of Medi-Cal discharges (including deaths, excluding newborns) in the hospital's accounting year, determines the total dollar limit on reimbursable cost for that accounting year.

Hospitals have been paid on an interim basis and a limit placed on the age of claims since 1966. Common Medicare and Medicaid audits have been proposed. The nursing home reimbursement system established rate ceilings, index reimbursement rate to economic trend factors and placed caps on administrative salaries as of 1966.

Physicians are reimbursed on the basis of a fee schedule. Reimbursement since 1966 has been at the rate for service when it was delivered, not billed and at the rate where service was delivered, not from where it is billed. Reimbursement for office or ambulatory surgery is at the operating room rate, also since 1966.

Nurse practitioners and physician assistants are both reimbursed indirectly by the Medicaid program. The reimbursement ration for NP and PA services are the same as the physician services.

Medi-Cal is currently developing and studying systems of selective participation of those providers identified as providing higher quality and/or cost effective services. They are considering various models for limiting the number of hospitals participating in the Medi-Cal program. One possible model is the selection of only those hospitals which provide quality, accessible service at the lowest cost. They are also organizing Medi-Cal payment data into Diagnosis Related Group (DRG). Once this hospital cost data are adjusted for case mix, they will be able to move readily compare hospital costs and determine for specific areas the potential cost-savings for Medi-Cal. They will then be able to examine more closely the impact on patient access and quality of care.

The state plan for monitoring PSRO utilization review activities involves a random sample of 7-20% of PSRO approved claims from PSRO's dischange listing. Measurement is by percent difference between what the state considers appropriate. Exceeding 2% at the low end of the performance range (after facturing out the error interval) constitutes PSRO failure of that monitoring cycle. To resolve conflicts between state monitoring and PSRO results: 1) face to face exit conference between state and PSRO physicians are held; and, 2) Post exit conference PSRO appel of disputed cases to CA Statewide PSRO Council for opinion advisory to the state.

All elective institutional admissions and some ambulatory services require prior authorization. These requirements were established in 1972 for all elective medical services. In 1975, preservice controls were removed from all ambulatory services except physician and occupational therapy, allergy, dermatology, psychiatric office visits in excess of 8 and 120 days, and non-emergency medical transportation.

Utilization control adopted at the start of the program in 1965 require participating providers to provide access to medical records and disallowance of claims. Changing coverage for reimbursement rate for administrative days from cost to flat rate is being studied.

The number of Medicaid recipients enrolled in prepaid group practices decreased from 124,547 in 1978 to 113,503 in 1980. While no formal program exist to encourage group practice to enroll recipients, the state has taken an active stand in encouraging existing HMOs to add a Medicaid component to their enrollment, and is currenly engaged in discussion with eight organizations who are federally qualified but have yet contracted with the state. By virtue of an external technical assistance contract, limited through expert assistance has been made available to potential Medicaid contractors. In a related vein, legislation is currently under way to establish a pilot project to guarantee for up to 6 months Medi-Cal eligibility for enrollment in a prepaid health plan.

A MMIS has been implemented and the state contracts out for dental claims processing.

Total Medicaid expenditures rose from $3,090.464 million in 1978, to $3,743.057 million in 1980. The state's outlay grew from $1,817.072 million to $2,127.363 million while federal outlays increased from $1.273.392 million, to $1,615.694 million. In each year the state's contribution was larger than the federal contribution, California's proportion begining 58.8% in 1978, 58.03% in 1979 and 56.84% in 1980; while the federal proportion each year was 41.2%, 41.97% and 43.16%. Provider reimbursement rates also increased from 1978 to 1980. Average per day hospital room reimbursement rate (including ancillary costs) rose from $166 in 1978 to $211 in 1980 or 27.1%, average physician rate per office visit from $12.15 to 13.0 or 7% average SNF rates from $20.42 to $24.43 or 19.64%, average ICF rates from $15.41 to $25.78 or 67.3% and average home health visit rate from $20.8 to $22.0 or 5.8%.

For the categorically needy, Colorado Medicaid program removed the more restrictive factors applied to the blind, the disabled and the elderly in 1979. That move is expected to add approximatley 1000 persons to enrollment. The elimination of spend down for the categorically needy in 1978 is expected to affect enrollment by 1,000. The medically needy program is not part of Colorado's program.

During 1969 two measures were adopted to control administrative errors and costs in eligibility determination; they are consolidation of welfare and medicaid eligibility applications and training of eligibility determination workers. Monitoring of their performance was started in 1970. Two other measures adopted in 1975 are retrieval of Medicaid ID cards from eligibiles and Medicaid quality control. To minimize client errors, provider telephone inquiries to the state to determine eligibility status were implemented in 1969, monitoring of client income through linkages with other employment data files began in 1970, photo ID implemented in 1974 and monthly client status reports were required in 1976.

A program to recover Medicaid funds from the Veterans Administration and health insurance was started in 1969 and in 1971 through federal financial participation through retroactive medicaid eligibility determination. Casualty insurance has also been proposed as another possible source of fund retrieval.

In 1979, Medicaid covered services were extended to cover rural health clinics and provision of services by a mental health clinics. Changes in expenditure are expected to be $54,000 and $540,000, respectively. In 1980, lock in for abusers of Medicaid benefits was implemented for a change in expenditures of $40,000.

By and large, mandatory benefits increased from 1978 to 1980, rising from $22.324 million in 1978 to $30.724 million in 1980. Outpatient hospital services and rural health clinics also increased from $5.958 million in 1978 to $8.153 million in 1980. Lab and x-ray funds declined from $1.982 million to $1.744 million, from 1978 to 1980. SNF funds rose 31.1 percent from $20.457 million in 1978 to $26.820 million in 1980; physician services rose 2.5 percent from $490.018 to $1.715 million and early and periodic screening and diagnostic testing by 19.37 percent from $1.642 million to $1.960 million over the same period. Optometrists funds declined from $52,332 in 1978 to $50,121 in 1979.

Optional expenditures for home health care rose from $303,071 in 1978 to $410.156 in 1980. Mental health clinics were allocated $536,377 in 1980. Drug expenditures rose from $9.345 million in 1978 to $10.5 million in 1980. Funds for diagnostic, screening, preventive and rehabilition services declined from $274,496 in 1978 to $246,318 in 1979, a decline of 11.44 percent; and expenditures by institutions for mental diseases for those sixty-five and older increased from $927,992 in 1978 to $1.211 million in 1980. ICF funds grew from $53.4 million in 1978 to $99.381 million in 1980. Funds for psychiatric hospitalization for those under 21 increased 50.43 percent from $3.609 million in 1978 to $5.429 million in 1980.

Colorado reimburses hospitals on a prospective all inclusive per diem basis. The rate is established by direct hospital negotiation under the state plan. The hospital reimbursement system placed a limit on the age of claims in 1972, established tape to tape billing in 1978 and common Medicare and Medicaid audits in 1980. Payment of all hospitals on an interim basis has been proposed. Indexing the reimbursement rate to economic trend factors was implemented in 1978. In 1975 reimbursement according to peer grouping was implemented.

Physician services are reimbursed on the basis of usual, customary and resonable charges which are updated on an annual basis based upon changes of the previous year. Two methods implemented in 1979 to reimburse physicians are CPT-4 and IMCD-9. In December of 1978, the pharmacy dispensing fee was changed by 40 cents and again in July 1980 by 50 cents, increasing expenditures by $200,000 and $375,000, respectively. A Colorado plan for monitoring PSRO utilization review activities is being developed.

The first utilization control measure was adopted in 1968 and required participating providers to give access to medical records. Provider education was implemented in 1969 along with the required identification of the ordering physician on prescription claims. In 1979, lab and x-ray claims also require the ordering physician's identification. Surveillance and utilization were also required in 1979 and in 1980; and the state began to lock in high users to one physician.

Medicaid recipients enrolled in prepaid group practices grew from 4,188 in 1978 to 5,406 in 1980. The 1979-1980 Colorado legislature funded a training grant for a HMO/Medicaid program. The money was used to conduct four state-wide training sessions and fund four county personnel. The purpose was to encourage recipient enrollment through helping the county personnel to be more aware of the HMO program and of the option it offers to Medicaid recipients and the reasons why the state and federal governments are supportive of the concept. However, Colorado HMO Choice Care went bankrupt in December 1979 and Medicaid lost its largest HMO.

A Medicaid Management Information System was implemented in 1979 and as of 1969 Medicaid has contracted out for a fiscal agent.

Medicaid expenditures grew from $152.707 million in 1978, to $179.0 million in 1980. Proportionately, the state contributed 46.29 percent of the total in 1978 and 46.84 percent in both 1979 and 1980. The federal government contributed 53.71 percent in 1978 and 53.16 percent in both 1979 and 1980. In absolute terms, the state contributed $70.689 million, $76.387 million and $83.844 million, an increase of 18.6 percent from 1978 to 1980. The federal outlay over the three years was $82.020 million, $86.693 million and $95.156 million, an increase of 16.0 percent from 1978 to 1980.

DELAWARE

Delaware's Medicaid categorical eligibility was extended in 1979 when the state began covering individuals under age 21 who receive a General Assistance Grant, for a change in enrollment of 1,014. AFDC standards were also increased in 1979, changing enrollments by 275. In 1980, eligibility standards for nursing home residents increased to 180% of the SSI standard increasing enrollment by 824. There have been no changes in eligibility for the medically needy.

In 1967, continuous training of eligibility determination workers and monitoring of their performance were instituted to control administrative errors of costs in eligibility determinations. Retrievals of Medicaid cards from ineligibles was adopted in 1974. Other proposed measures to check costs and errors are the development of a client information system with automated eligibility capability and the consolidation of welfare and Medicaid eligibility applications. As of 1967 provider verification of client identification and provider telephone inquiries to the state to determine eligibility status were adopted. Clients also are required to personally pick up checks at all times and a photo ID has been used since 1974. The monitoring of client income through linkages with other employment data file has been practiced since 1978.

As of 1978, Medicaid instituted a program to recover funds from absent parents, the Veteran's Administration, health and casualty insurance and through federal financial participation recovery through retroactive Medicaid eligibility determination.

Several Medicaid services were changed during 1979 and 1980 to provide more services to recipients. In 1979, those under 21 years were added to the Medicaid program at an estimated cost of $369,000. The pharmacy dispensing fee was increased from $2.0 to $2.75 at an annual cost of $225,000. Eligibility standards for nursing home residents also were increased in 1980 at a cost of $10.5 million and the pharmacy dispensing fee was once again increased from $2.75 to $2.95 for a total cost of $60,000.

Mandatory Medicaid expenditures generally increased during the 1978-1980 period. Inpatient hospital services increased from $8.741 million in 1978 to $11.246 million in 1980. Funds for outpatient hospital services and rural health clinics also increased from $2.053 million in 1978 to $2.768 million in 1980. Lab and x-ray expenditures declined from $302,781 in 1978 to $261,757 in 1980, while SNF funds increased from $246,923 in 1978 to $524,876 in 1979 and then declined to $347,137 in 1980. From 1978 to 1980 physician services rose 26.32 percent from $3.8 million to $4.8 million, early and periodic screening and diagnostic testing by 47.8 percent, from $358,457 to $530,576 and family planning increased over 458 percent from $148,644 to $828,834. Optional benefits such as home health care rose from $97,549 in 1978 to $342,950 in 1980. From 1978 to 1980, expenditures for drugs also rose from $1.6 million to $1.9 million, and funds for ICF from $11.4 million to $18.5 million. Expenditures on institutions for mental diseases for those 65 and older declined from $1.2 million to $0.9 million over the same period.

The state's hospital reimbursement system adopted in 1978 the disallowance of weekend admission reimbursement for non-emergency services. In 1975, the system began to limit the age of claims, and payment of all hospitals on an interim basis was instituted in 1976. Common Medicare and Medicaid audits were also instituted in 1979 and tape to tape billing has been proposed. A series of measures were adopted in 1977 by the nursing home reimbursement system including establishment of rate ceilings, elimination of efficiency incentives, imputing a useful life time of 40 years on nursing home facilities and identical treatment of leased and owned facilities. In 1978, reimbursement according to peer grouping was adopted and indexing of reimbursement rates to economic trend factors in 1979. One measure proposed for adoption is submission of a single invoice for all nursing home patients.

Physician services are reimbursed on the basis of usual, customary and reasonable charges. Maximum charges are updated annually with the index equal to the 75th percentile of charges to Medicare. In reimbursing physicians, a limit on the number of billable procedures and reimbursement at the rate for service when it was delivered, not billed, has been adopted. Increases in Medicaid reimbursement rate as of June 1978 were made to accomodate inflation.

Several utilization control measures were adopted by the state beginning with the requirement that participating providers give access to medical records. In 1977, limitations on the length of stay for stays without PSRO approval were adopted and provider education and lock-in of high users to one physician were implemented in 1978. As of 1979, coverage or reimbursement rate for administrative days were changed from unlimited to 28. Medicaid recouped overcharged funds from 4 providers in 1979 and from 24 in 1980.

Medicaid expenditures grew from $30.4 million in 1978 to $45.7 million in 1980. State and federal contributions to the total amount were evenly divided in each year. Along with the increase in funds, Medicaid enrollment increased from 38,618 in 1978 to 44,011 in 1980. Average reimbursement rates per day from 1978 to 1980 in a SNF rose from $24.44 to $31.93, for a private ICF from $23.82 to $29.67, and in a state ICF $36.0 to $48.25. An average home health visit for a nurse went from $19.58 to $23.44 and for an aide from $12.11 to $17.21. An office visit to a non-specialist physician rose 22.7 percent, from $15.0 to $18.40 over the same time period.

Income standards for AFDC recipients were increased for the categorically eligibles in 1979 and 1980, and resulted in enrollment growing from, 2548 to 17,000.

Efforts to control administrative errors and costs in eligibility determination have been adopted, beginnning in 1970 with the consolidation of welfare and Medicaid eligibility applications and retrieval of Medicaid ID cards from ineligibles. Prior to 1969 eligibility determination workers have been trained and their performance monitored. With the regorganization of the Department of Health and Rehabilitative Services in 1975, efforts were signifcantly improved. In 1970 provider telephone inquiries to the state as to eligibility status were implemented in an effort to minimize client errors.

To recover Medicaid funds the state implemented a program to retrieve funds from the Veteran's Administration, health and casualty insurance, and through federal financial participation in retroactive Medicaid eligibility determination. Absent parents were made a source for fund retrieval in 1978.

Florida Medicaid covered services were changed in 1978 with the elimination of dental examination and education for a change in expenditures of $635,153 and a limit of three physician visits per month, with a corres-ponding expenditure change of $44,550. In 1980, adult dental, visual and hearing programs were added at a cost of $13 million.

Expenditures for mandatory Medicaid expenditures for inpatient hospital services increased by 51% from $79.462 million in 1978 to $120.087 million in 1980. Over the same period funding for outpatient hospital services and rural health clinics increased from $10.462 million to $21.543 million, an increase of 106%. Lab and x-ray funding declined from $690,704 in 1978 to $328,004 in 1980. From 1978 to 1980 both SNF and physician service funding increased, from $43.030 million to $53.922 million for SNF, and $26.395 million to $32.744 million for physician services.

Similar patterns prevailed with EPSDT and family planning funding. EPSDT funds declined from $5.715 million to $5.617 million, while family planning funds declined from $881,916 to $791,728. Funding for optional benefits such as home health, drugs and ICFs increased each year. From 1978 to 1980 home health funds increased 177% from $291,046 to $807,020, for drugs from $25.055 million to $31.148 million, and for ICF care from $54.194 million to $71.159 million. Funding for institutions for mental diseases for those sixty-five years or older declined from $6.294 million in 1978 to $5.852 million in 1980.

The state's hospital reimbursement system adopted disallowance of weekend admission reimbursement for nonemergency services in 1970. In 1980 the state has proposed an imputed occupancy rate. The hospital system has also instituted common Medicare and Medicaid audits, placed a limit on the age of claims in 1980 and instituted denial of reimbursement for 8.5% nursing cost differential in 1970. In 1970 caps were placed on administrative salaries, rate ceilings established and reimbursement

rates tied to grades of patient disability by the nursing home reimbursement system. As of 1978 the reimbursement rate has been indexed to economic trend factors.

Physician charges on Florida are reimbursed on the basis of a fee schedule. In reimbursing physicians a limit has been placed on the number of billable procedures, and reimbursement is at rate for service when it was delivered, not billed. During 1978 Medicaid reimbursement rates were changed through the reduction of physician fees by 5% and a limit on physician cross over payment to Medicaid allowable, reesulting in expenditures decreases of $1.207 million and $3.122 million, respectively. Florida's Medicaid program reimburses nurse practioners directly and physician assistants indirectly at the rate of $12.0 per office visit.

State monitoring of PSRO utilization review activities occurs by review of a special PSRO monitoring report, which includes the Mediciad Information System data by hospital in the PSRO area. Of all the claims which have been paid, the report will indicate 10% of those for which the number of days certified by the PSRO exceeded the 50% PAS norm. Measures used in the review include days certified by PSRO exceeding the 50% and 90% PAS norms, inappropriate admissions, discharges, length of stays and setting. When deficiencies, problems or areas needing improvement are discovered, the state agency contacts the appropriate PSRO and discusses the situation; action is cooperatively initiated. If disagreement occurs between the state agency and the PSRO and it cannot be resolved, the Mediciaid office will utilize the compliant system developed by HEW to solve the disagreement.

Medicaid is currently developing procedures for preadmission screening of individuals applying for Medicaid eligibility for nursing home care. The preadmission screening team will be composed of a physician, nurse, and social worker. The team will undertake a comprehensive patient assessment, which will include the patient's medical history, mental and social functioning, a rating of activities of daily living and long term care service needs. For persons who can be maintained in the community through community programs/service and living arrangements, Medicaid nursing home reimbursement will be denied. This plan will be implemented on a pilot basis before being implemented statewide during fiscal year 1980-81.

Utilization control measures, including requiring participating providers to give access to medical records, were implemented in 1970. Provider education and a limit on the length of stay for stays without PSRO approval were adopted in 1978. During 1979 fines were levied against one Medicaid provider.

2500 Mediciad recipients have been proposed for enrollment in a prepaid group health program. There is a demonstration project to test the concept in one county and the state will encourage other HMOs to participate in Medicaid. MMIS was implemented in 1978 and bulk purchasing in 1980. Medicaid will begin contracting out for EPSDT case management in 1981.

Total Medicaid expenditures increased from $268.999 million in 1978 to $392.826 million in 1980. State funds increased by 36.46% in this

period from $98.050 million to $133.797 million, and federal outlays from $152.189 million, to $231.512 million, an increase of 52.21%. The local share increased by 46.0% from $18.230 million to $27.498 million over the same period. Proportionately, local government contributed 7% of the total in each year, the state 36.45% in 1978 and 34.06% in both 1979 and 1980 while the federal share in 1978 was 56.55% and 58.94% in both 1979 and 1980.

Total categorical Medicaid enrollment rose from 410,440 in 1979 to 439,884 in 1980. The average day hospital room reimbursement rate increased from $163.95 in 1978 to $208.93 in 1980, while nonspecialist physician office rate remained $15.00 in each of the three years. From 1978 to 1980 SNF rates rose 21.24% from $17.47 to $21.18, and ICF rates by 17.15% from $15.74 to $18.44. Average home health visit rate remained $15.00 in 1978 and 1979 and declined to $14.15 in 1980.

In Fiscal Years 1980 and 1981, Medicaid caps on income for the categorically eligible were increased in response to increase payments. AFDC and SSI were also increased. A change in recipient residency requirements was implemented in fiscal year 1980. These three provisions will increase enrollment 500, 5,000 and 200, respectively.

To control administrative errors or costs, training of eligibility determination workers was instituted in 1979. Error prone profiling and monitoring of the eligibility workers performance have been proposed for adoption. To reduce client error, provider telephone inquiries was instituted in 1979 and a colored non-duplicative ID in 1981. Identification cards for nursing home patients were eliminated in 1980.

Absent parents and federal financial participation recovery through retroactive eligibility determination are two of the sources from which the Medicaid program tries to recover funds as of 1978. In 1979, the program attempted to recover funds from health and casualty insurance. The Veterans' Administration also has been proposed as a source for recoupment.

Medicaid coverage was extended to emergency dental service for adults over 21, and a lowest charge provision implemented on certain laboratory procedures. The first provision is expected to cost an additional $700,000 and the second a savings of $15,000 annually. In 1981, enrollment in out-of-state nursing homes was added at an annual cost of $4.5 million.

Mandatory Medicaid expenditures for inpatient hospital services grew from $94.740 million in 1978 to $99.040 million in 1979, and in the first 8 months of Fiscal Year 1980 expenditures reached $66.238 million. Expenditures for outpatient hospital services and rural health clinics grew slightly from 1978 to 1979 from $14.872 million to $14.941 and expenditures reached $11.825 million in the first 8 months of 1980. From 1978 to 1979, lab and x-ray funds declined from $417,637 to $393,665, early and periodic screening and diagnostic testing from $1.905 million to $1.187 million, family planning from $2.282 million to $1.924 million, and optometrist care from $580,589 to $544,542. Two of the largest mandatory expenditures are for SNF and physician services, both of which increased from 1978 to 1979, from $52.923 million to $54.910 million and from $34.624 million to $35.299 million, respectively.

Optional benefits for medical and other remedial care increased from $1.803 million in 1978 to $3.608 million in 1979. Home health care expenditures increased from $818,079 in 1978 to $1.232 million in 1980. Over the 1978-1979 period, clinic services for mental health grew from $3.411 million to $4.109 million, dental care from $7.529 million to $7.385 million, and dentures, prosthetics and eyeglasses from $538,311 to $629,547. Spending for institutions for mental diseases for those over 65 for expenditures declined from $78,698 to $62,309. The two largest optional expenditure items are for drugs which grew from $34.635 million in 1978 to $37.0 million, in 1979 and for ICF care which grew from $102.651 million to $120.550 million.

As of October 1980, Georgia's Medicaid system for paying hospital inpatient services was revised to: 1) group hospitals by case mix and service characteristics; 2) compare per case cost after excluding non-comparable and non-controllable cost components; 3) determine prospective target rates based on prior year cost, efficiency incentives, penalties and projected cost increases; 4) adjust target rates based on actual cost and services; and, 5) make payment based on adjusted target rates. The hospital reimbursement system has paid hospitals on an interim basis since 1967 and conducts common Medicare and Medicaid audits as of 1975. In 1967, a limit was placed on the age of claims, the denial of reimbursement for 8.5 percent nursing cost differential was instituted in 1974, and tape to tape billing in 1978. The state's nursing home reimbursement system implemented submission of a single invoice by nursing home for all patients in 1975, and in 1978 established rate ceilings, reimbursement according to peer grouping, limits on capital costs and on pass-throughs, and setting limits by cost centers. Other measures adopted in 1978 include indexing reimbursement rates to economic trend factors and setting caps on administrative salaries.

Physicians are reimbursed on the basis of usual, customary and reasonable charge although a fee schedule has been proposed. The reimbursement rates were established in 1974 and will be updated with a fee schedule in Fiscal Year 1981. In reimbursing physicians, as of 1973 there has been a limit on the number of billable procedures, reimbursement at the rate when and where service was delivered, not from when and where service is billed, and reimbursement for office or ambulatory surgery at hospital operating room charges. In 1981 the physician fee schedule will be changed, resulting in increased expenditures of $2.5 million; the cost of non-covered medical care will be deducted from patient income and applied to nursing home costs for an expenditure change of $4.0 million annually.

The PSRO in Georgia did not assume binding review until October, 1980. The monitoring plan which the Department of Medical Assistance will utilize has not been finalized for submission to DHHS. It is anticipated, however, that the approved plan will consist of a monitoring of aggregate statistics (number of discharges, length of stay, average pre-op days, percent of Friday-Saturday admissions, percent of Sunday-Monday discharges, etc.) against a baseline occuring prior to the assumption of binding review, as well as a case by case review of the allowable 20 percent sample to evaluate the medical necessisty of admission, appropriateness of setting, necessity of ancillary services rendered and length of stay, etc. To resolve conflicts between state monitoring and the PRSO, proposed methods contained in the draft would involve working informally with the PSRO in attempting to resolve any disputes and calling on the HCFA regional administrator's office to intervene in any irreconcilable matter.

Prior authorization of selected services began in 1975. Services which require prior authorization are keloids and obesity surgery; physical therapy for more than 24 treatments in 8 weeks; dental care over $100 and hospitalization; DME; eyeglasses and/or one diopter and more than one pair per year; contact lenses; drugs not on formulary; more than 1 visit to a podiatrist per month; ambulance trips between

institutions over 100 miles; out-of-state services; and, nursing home placements.

The state has adopted utilization control measures such as disallowance of claims, provider education and the requirement that participating providers give access to medical records. Required identification of the ordering physician on laboratory, x-ray and prescription claims and lock in of high users to one physician have been proposed.

In 1979, three providers were removed from the Medicaid program and five in 1980, and three placed on probation in both 1979 and 1980. During 1980, six providers have been indicted and are awaiting trial and five indictments are pending. A total of $6,000 in fines also were levied against providers in 1979 and $5,400 in 1980. In addition, $214,501 in overpayments were identified in 1979 and $255,250 in 1980. Overpayments to clients that have been identified totaled $3,152.63 in 1979 and $6,345.48 in 1980. Fines levied against clients totaled $800 in 1980 and one client received a jail sentence. Three clients were placed on probation in 1979 and one in 1980, while two have been indicted and are awaiting trial and one has an indictment pending in 1980.

Georgia has no welfare recipients enrolled in prepaid group practices. Two HMOs in Georgia were federally qualified in early 1980 and DMA may contract with them for provision of services to eligibles in 1981 and 1982. A Medicaid Management Information System was implemented in Georgia in 1976.

Between 1978 and 1979, total Medicaid expenditures grew 8.2 percent, from $353.808 million to $382.213 million, and in the first eight months of Fiscal Year 1980 was $271.128 million. The state's share of Medicaid remained at 33.33 percent during both years at $117.936 million and $127.604 million, and the federal share was 66.67 percent in both years at $235.872 million and $255.209 million. Between 1978 and 1979, however, total Medicaid enrollment declined from 421,160 to 403,778, but had reached 403,108 in the first eight months of Fiscal Year 1980. During 1978, 1979 and 1980, the average non-specialist physician rate per office visit remained at $16.65, while the average rate per day in an SNF increased from $14.27 to $18.85. ICF rates rose from 1978 to 1980 from $16.84 to $22.15. and the average home health care visit rate grew from $23.76 to $32.20.

The state or Hawaii has made a number of changes in its Medicaid program. For the categorically eligible, the unearned income disregard policy was terminated and the medical standard changed. In regards to the medically needy, excess income and resources after deduction of incurred medical expenses are considered available for cost sharing of medical care and services.

To control administrative errors and costs in eligibility determination, error prone profiling, consolidation of welfare and Medicaid eligibility applications, retrieval of Medicaid ID cards from ineligibles, training of eligibility determination workers and the monitoring of their performance were implemented. Monthly client status reports, provider vertification of client identification and provider telephone inquiries to the state as to eligibility status were instituted to reduce client eligibility errors.

As of 1966, Hawaii's Medicaid program has attempted to recover funds from the Veterans' Administration, health and casualty insurance and through federal financial participation recovery in retroactive Medicaid eligibility determination.

Mandatory Medicaid expenditures for inpatient hospital services were $16.111 million in 1978 and $21.751 million in 1979, an increase of 35 percent. Other large mandatory expenditures from 1978 to 1979 were for SNF which increased from $17.618 million to $19.183 million, and for physcian services which rose from $12.027 million to $17.759 million. Over the same period, funds for outpatient hospital services and rural health clinics increased from $2.954 million to $4.045 million, lab and x-ray services rose from $1.929 million to $2.924 million, and early and periodic screening and diagnostic testing grew from $58,194 to $124,630. Family planning funds declined from $363,234 to $283,828 over the same period. Optional benefits such as home health care grew from $254,058 to $363,686, drug funds from $4.521 million to $6.155 million, and ICF funds from $15.514 million to $15.700 million.

The state's hospital reimbursement system has implemented: denial of reimbursement for percentage contracts for laboratory and x-ray services, disallowance of weekend admission reimbursement for non-emergency services, a limit on reimbursement rate for services to a rate of least expensive setting, and imputed on occupancy rates. All hospitals are paid by the state on an interim basis as of 1969 and beginning in 1972 common Medicare and Medicaid audits are conducted by the state. In 1971 a limit was placed on the age of claims which will be reimbursed, and reimbursement of hospitals has been on a department basis since 1969. Since 1976, the denial of reimbursement for an 8.5 percent nursing cost differential has been implemented. Hawaii's reimbursement of nursing homes is based on Medicare policy.

Physician services are reimbursed on the basis of usual, customary and reasonable charges. These charges have been updated once by the legislature since adoption in 1976. Reimbursement of physicians is at the rate for service when it was delivered, not billed, and at a rate for

where service was delivered, not from where service is billed.

At present, the monitoring of PSRO is carried out for acute hospital care. Claims for length of stay and all ancillary charges are computerized, utilizing the fiscal intermediary under contract to the department. Printouts on length of stay and ancillary charges are made for each hospital by diagnostic category on a quarterly basis. Ancillary charges are grouped as laboratory, x-ray, pharmacy, supply and miscellaneous. No satisfactory process has been developed as yet to resolve conflict between state monitoring and PSRO results and such a process is currently been developed.

Proposals are currently under consideration to require prior authorization for certain dental services and elective medical procedures, physical and occupational therapy, podiatry services for patients in acute hospitals, short-term inpatient psychiatric admission, group therapy and detoxification, among others.

Utilization controls adopted by the state include the requirements that participating providers give access to medical records, identification of the ordering physician be on laboratory, x-ray and prescription claims and the lock-in of high users to one physician. In 1979 ten providers were suspended from the Medicaid program and five sentenced to jail terms. In 1978, 2,806 Medicaid recipients were enrolled in prepaid group practices and 2997 enrolled in 1979. Kaiser outreach workers are stationed at application sites and written materials on various aspects of prepaid group practices are available to recipients. A Medicaid Management Information System has been implemented and the state contracts out to a fiscal intermediary to enhance program administration.

In 1978, Medicaid expenditures totalled $93.4 million and increased to $104.694 million in 1979. The state and federal government contributed equally to the total in both years. Average per day hospital room reimbursement rate rose from $182.61 to $198, or 8.4 percent from 1978 to 1979. Over the same period, average per day rate in a SNF rose 12.66 percent, from $44.22 to $49.82 and in an ICF rates increased 6.0 percent from $36.7 to $38.90.

Both in 1978 and 1979 the adult categorical need standard was increased, including that for the institutionalized. In 1980, when this category was again increased, the institutionalized were excluded, decreasing enrollment by 85.

To control eligibility errors or administrative costs in eligibility determinations, retrieval of Medicaid ID cards from ineligibles, training for eligibility workers and monitoring of their performance were adopted in 1970. Error prone profiling was implemented in 1975. To reduce client error, monitoring of client income through linkages with other employment data files and monthly status reports were implemented in 1972 and 1973, respectively. Provider telephone inquiries to the state to determine eligibility status was implemented in 1978.

Programs were implemented to recover Medicaid funds from absent parents in 1974, from the Veterans Administration in 1980, from health insurance in 1978, from casualty insurance and through the federal financial participation recovery through retroactive medicaid eligibility determination in 1980.

A 50 cent copayment on drugs and elimination of vitamins and drugs for obesity saved Medicaid $175,000 in 1980. Personal care services will be added in 1981 at a cost of $500,000.

Medicaid expenditures for mandatory benefits increased from 1978 to 1980. Inpatient hospital services increased from $5.899 million in 1978 to $7.441 million in 1979 and to $9.651 million in 1980, an increase of 63.6 percent. Outpatient hospital services and rural health clinic funds increased from $1.335 million in 1978 to $1.565 million in 1980, and lab and x-ray expenditures from $335,900 to $630,000 in 1980. SNF expenditures grew from $6.256 million to $8.918 million over the three years from 1978 to 1980, or by 42.55 percent. Physician services increased from $3.997 million to $4.710 million from 1978 to 1980. Funds for early and periodic screening and diagnostic testing increased from $326,400 to $401,300, while family planning and optometrists services rose from $150,600 to $177,700 and from $126,600 to $247,200 respectively over the same time period.

From 1978 to 1980 optional benefits for medical or other remedial care declined from $142,500 to $113,500; home health care spending increased from $83,300 to $127,600, and funds for mental health clinics from $170,800 to $429,300. Dental care expenditures grew at a lower rate, from $751,500 to $797,600 while physical, occupational and speech therapy rose from $87,500 to $142,700. Funds for drugs went from $1.818 million to $2.271 million. Finally, diagnostic, screening, preventive and rehabilitation services grew from $124,700 to $304,000 and for ICF care from $17.422 million to $22.341 million, or 28.23 percent.

The state's hospital reimbursement system began imputing an occupancy rate in 1979. As of 1974, all hospitals are paid on an interim basis and common Medicare and Medicaid audits were implemented in 1979. The age of claims has been limited since 1978 and tape to tape billing recently has been proposed. The state's nursing home reimbursement system implemented caps on administrative salaries, identical treatment of leased and owned facilities and submission of single invoices by nursing homes for all patients in 1974. In 1979, rate ceilings and reimbursement according to peer grouping were established; limits were set by cost centers and the reimbursement rate indexed to economic trend factors.

Physician services are reimbursed according to a fee schedule. As of 1978 reimbursement for the services is at the rate for the service when it was delivered, not billed and at the rate where the service was delivered, not billed.

In 1979, Idaho's Medicaid reimbursement rates and copayments were changed. All prescriptions require a 50 cents copayment, resulting in savings of $150,000. Nursing homes allowable costs were capped for savings of $4.3 million, while $600,000 was saved from a cost cap on hospital inpatient services.

The state is currently proposing to reimburse nurse practitioners and physcian assistants indirectly under the Medicaid program. Prior review and authorization is required by the state for certain procedures. For elective surgery, a physician consultant in Medicaid must review and approve the surgery and the need for nursing home care must be reviewed by the State MSR Team prior to approval of care. The need for hearing aids also must be approved by a physician consultant. All these measures were implemented in 1978.

A series of utilization control measures were adopted in 1978 and 1980. Disallowance of claims and the requirement that participating providers provide access to medical records were implemented in 1978. In 1980 the following measures were implemented: questionnaires to recipients to verify services and charges; provider education; lock in of high users to one physician; patient education; and required identification of ordering physician on laboratory, x-ray and prescription claims.

In fiscal year 1980, the state recouped payments with damages from 5 providers. A Medicaid Management Information System , (MMIS), was implemented in 1978, along with a MMIS computer system and a dental UR review. Bulk purchasing of goods has been proposed.

In all, Medicaid expenditures totaled $39.753 million in 1978, $45.177 million in 1979 and $52.245 million in 1980, increasing 13.64 percent from 1978 to 1979 and 15.65 percent from 1979 to 1980. The federal government's share of the total was nearly constant over the three years from 64.64 percent in 1978 to 64.59 percent in 1980, while funds increased 31.35 percent, from $25.695 million to $33.750 million. The State's share increased from $14.058 million to $18.495 million, or 31.56 percent, and as a percent of total Medicaid expenditures was 35.36

percent in 1978 and 35.40 in 1980. Provider reimbursement rates increased, with per day hospital room reimbursement rates increasing from $134.92 in 1978 to $215.00 in 1980. Average per day reimbursement rate for SNF rose 29.27 percent from $16.16 to $20.89. ICF increased 24.28 percent from $16.23 to $20.17, while the home health visit rate decreased from $21.36 to $20.44 over the same period. The rate for a non-specialist physician office visit declined from 1978 to 1980, from $21.36 to $17.46, and is attributed to a drop in cost per service due to the implementation of the MMIS in January 1978.

ILLINOIS

Illinois' Medicaid standard for categorical eligibility was changed in 1978 by increasing the eligibility standard, and in 1979 through coverage of adult only AFDC parent with an SSI child, and by a change in the definition of unemployed father to unemployed parent. The latter change increased enrollment by 419 cases over 7 months. In 1978 and again in 1979, the medically needy eligibility standard was increased, while 1980 coverage was extended to childless pregnant women. This change increased enrollment by 1,888 as of April 1980, at an annual costs of $13.7 million.

The state has adopted several methods to control administrative errors and costs in eligibility determinations. Among the measures implemented in 1965 are the consolidation of Welfare and Medicaid eligibility applications, retrieval of Medicaid ID cards from ineligibles, training eligibility determination workers and monitoring their performance. A local office performance measure has been proposed in 1980. To reduce client errors in eligibility, the state implemented provider verification of client eligibility in 1965, photo ID in 1973 and limited personal pick up of checks in 1975. Monitoring of client income through linkages with other employment data files was also adopted in 1975. Provider telephone inquiries to the state to determine eligibility status is proposed for 1981.

Programs have been implemented to recover Medicaid funds from absent parents in 1975, from health and casualty insurance in 1979, and from federal financial partipation recovery through retroactive Medicaid eligibility determination. There is currently a proposal to recover funds from Medicare Part B.

Medicaid expenditures for mandatory benefits increased for most categories from 1978 to 1980. Inpatient hospital services received $477.1 million in 1978, $500.5 million in 1979 and $533.4 million in 1980, an increase of 11.8 percent. Funds to outpatient hospital services and rural health clinics rose from $52.0 million to $50.9 million to $55.0 million in three years. Lab and x-ray funds grew from $7.4 million in 1978 to $9.1 million in 1979 and then decreased to $9.0 million in 1980. Expenditures for skilled nursing facilities were $69.8 million in 1978, and increased to $90.1 million by 1980. Resources allocated for physician services rose from $102.5 million in 1978 to $117.1 million in 1980. Funds for early and periodic screening and diagnostic testing followed a similar pattern, increasing from $1.2 million in 1978 to $1.4 million in 1980. Family planning expenditures also decreased from $5.2 million to $4.8 in 1980. Funds for optometrists, podiatrists and chiropractors were $11.5 million in 1978, rose to $13.5 million in 1979, and then decreased to $11.4 million.

Optional benefits such as home care health received funds $1.7 million in 1978 and 1979 and $3.1 million in 1980, an 82.35 percent increase. Clinic services went from $38.3 million in 1978 to $44.0 million in 1980, and dental expenditures from $27 million to $30.1 million. Funds for physical, occupational and speech therapy, dentures, prosthetics, HMO and transportation increased from $30.8 million to $31.1 million from 1978 to 1980. Expenditures for drugs increased from $77.5 million

to $101.4 million and for intermediate care facilities from $175.6 million to $227.3 million, an increase of 29.44 percent.

The state's reasonable cost hospital reimbursement system includes payment of all hospitals on an interim basis, common Medicare and Medicaid audits and limiting the age of claims. The system further includes reimbursement on hospital department basis as opposed to a combination and the denial of reimbursement for the 8.5 percent nursing cost differential. Tape to tape billing has been proposed.

In 1978 the state's nursing home reimbursement system adopted the establishment of rate ceilings, reimbursement according to peer grouping, limiting capital costs, and tying reimbursement rates to grades of patient disability. Indexing the reimbursement rate to economic trend factors and putting caps on administrative salaries also were adopted in 1978. Pass throughs are limited to the extent that the prospective system used considers trends, although it does not incorporate specific individual pass-throughs. The state also treats leased and owned facilities in the identical manner.

Physician services are reimbursed on the basis of a fee schedule. Services provided by a physician are reimbursed at the rate for the service when it was delivered, not billed and is reimbursed at the rate where the service was delivered, not from where the service is billed.

Several aspects of Medicaid's reimbursement rate, rate ceilings and copayments will change in fiscal year 1981. Specifically, hospital rates will increase following current Medicare methodology for an estimated 13.7 percent increase in funds. Long term care reimbursement for nurses' aid training will increase for an additional $3.2 million. Salaries for direct services provided by homemakers will increase 8 percent, as will chore/housekeeper salaries. Medicheck screening will be raised from $8 to $15 and the school exam rate will rise from $11 to $15 for a total of $659,000. A quality incentive bonus for LTC high quality facilities will also be adopted, totaling $1.5 million. Dentists' fees will be raised by 9.4 percent, costing an additional $2.1 million, while amendments to the state plan for LTC facilities is expected to total $41.5 million.

The Illinois Medicaid program does not monitor PSRO utilization review activities, as the review is based on sampling. The plan has three components, the first a selective appraisal of PSROs concurrent review processes through the use of PMIS reports and limited on-site visits. The second component is a statistical monitoring of the impact of PSRO concurrent review activities on inpatient utilization for specific diagnosis, and thirdly an appraisal of PSRO retrospective health care review studies is conducted. Some of these have not been fully implemented as the Medicaid Management Information System is not itself fully implemented. To resolve conflicts between state monitoring and PSRO results, Illinois will utilize the HHA compliance system to address problems not amenable to solutions at the individual PSRO/State level.

Medicaid procedures which require prior review and authorization include morbid obesity surgery (1973), bone marrow transplant as of 1977, eye muscle surgery as of 1959 and home hyperalimentation as of

1979. All requests are reviewed by the Department's physicians and consultants and the second and third procedures also are reviewed by the State Medical Advisory Committee. Private duty nursing in a hospital has required prior authorization since 1969. Nursing in the home if there is no home health agency in the area requires prior authorization. Home health care has required prior authorization since 1976.

The following utilization controls have been adopted by the state: limitation on the length of stay for stays with PSRO approval; disallowance of claims; the requirement that participating providers provide access to medical records; identification of the ordering physician on laboratory and prescription claims; lock in of high users to one physician; and provider education.

In 1979, there were 6 suspensions of providers from the Medicaid program and 3 in 1980. A total of 32 providers were removed from the program in 1979 and 8 in 1980. There were 6 voluntary terminations by providers in 1979 and 3 in 1980. There were 16 jail sentences in 1979 and 10 in 1980 handed out to providers. Recoupment of funds from providers totaled $549,000 in 1979 and $724,000 in 1980.

The number of Medicaid enrollees in prepaid group practices in 1978, 1979 and 1980 were 25,389, 27,022 and 25,680, respectively. There is no program as such to either encourage prepaid group practices to accept Medicaid enrollees, and/or encourage Medicaid recipients to enroll in such practices. Recipients are encouraged to enroll through direct mailings by the agency highlighting benefits and the HMO programs available in their geographic area. Group practices are encouraged to accept Medicaid by an attractive per capita rate and reduced paperwork. To improve Medicaid program administration, the state implemented a Medicaid Management Information System in 1980 and will implement bulk purchasing of eyeglasses in 1981.

Total Medicaid expenditures rose from $1.070 million in 1978 to $1.253 million in 1980. Medicaid enrollment decreased from 1.018 million in 1978 to 939,000 in 1980, with categorical eligibles decreasing from 764,000 to 725,000 and medically needy decreasing from 255,000 to 149,000. Non-Medicaid state general assistance expenditures for medical care and aid to the medically indigent rose from $80.3 million in 1978 to $96.6 million in 1980. The number of hospital admissions declined from 403,225 to 345,666 between 1978 and 1980 while the average length of stay increased from 8.3 to 9.0 days. The number of days of care SNF rose from 3.9 million to 4.1 million and ICF days of ICF care rose from 14 million to 15.5 million from 1978 to 1980. From 1978 to 1980 the average provider reimbursement rate for a non-specialist physician visit grew from $20.99 to $26.49, for SNF from $17.74 to $22.50 and for ICF from $12.30 to $16.00. The weighted average rate for home health visits remained at $34 for each fiscal year.

For the categorically needy, 1978, 1979 and 1980 standards changes include an increase in flat maintenance allowance to match SSI and changes in parental responsiblity. Changes in 1979 and 1980 include an increase in standard resource allowances, change in NH patients' family responsibility and a liberalization of the sheltered workshop disregard. Residency requirements were changed in 1979 and in 1980 parental responsiblity for NH residents ends at 18 rather than 21 and a disregard of $1000 life insurance policy for certain resources was implemented.

To control administrative errors and costs in eligibility determinations, retrieval of Medicaid ID cards from ineligibles and training of eligibility determination workers were implemented in 1970 and monitoring of eligibility workers performance in 1973. Provider verification of client identification was implemented in 1970 and photo ID in some some areas.

As of 1970 the state has recovered Medicaid funds from health and casualty insurance, the Veteran's Administration and through federal financial participation in retroactive Medicaid eligibility determinations. Funds have been recovered from absent parents as of 1976.

Medicaid coverage has been extended to all medically necessary abortions as of February 1980 and coverage extended to CRF (Community Residential Facilities) at a cost of S1.0 to $1.6 million in FY 1980. Mandatory expenditures for inpatient hospital services rose from $61.992 million in 1978 to $79.567 million in 1980, an increase of 28.35%. All other mandatory service funds also increased from 1978 to 1980--for lab and x-ray from $622.0770 million to $797.917 million, SNF from $30,464 million to $42.330 million, physician services from $22.115 million to $25.870 million, and planning from $123,498 to $168,641. Optional funds for home health care rose in this period from $1.657 million to $1.955 million, while private duty nursing declined from $218,492 to $28,560. From 1978 to 1980 dental service funds grew 22.2% from $4.664 million to $5.699 million, pharmacist from $20.681 million to $24.898 million or 20.4%, ICF funds from $97.374 million to $132.449 million or 36%. Other optional programs also increased over the same period such as physical, occupational and speech therpy from $223,927 to $769,257, institution for mental diseases for those sixty-five and older from $1.531 million to $1.617 million, psychiatric hospitalization for those under twenty-one from $1.356 million to $4.167 million and optometrist funds from $1.393 million to $1.646 million.

The state hospital reimbursement system pays hospitals on an interim basis and conducts common Medicare and Medicaid audits. The state implemented denial of reimbursement for 8.5% nursing cost differential and placed a limit on the age of claims in 1970. Tape to tape billing was implemented in 1975, and the nursing home system began identical treatment of leased and owned facilities in 1979. Several other measures were adopted in 1976 including the establishment of rate ceilings, reimbursement according to peer groupings, a limit on capital costs, setting limits by cost centers, indexing the reimbursement rate to economic trend factors and caps on administrative salaries.

Physician services are reimbursed on the basis of usual, customary and reasonable charges. All fees are updated annnually on July 1st based on the preceding year's charges. Physicians are reimbursed at the rate for service when it was delivered, not billed and at the rate where service was delivered, not from where service is billed. Changes in Medicaid reimbursement rates include an increase in dispensing fee at an additional cost of $1.4 million per year and the redefinition of a drug claim, saving $1.2 million per year. Both physician assistants and nurse practitioners are reimbursed indirectly by the Medicaid program. Indiana has no state monitoring plan of PSRO utilization review activities.

Out of state medical services, except those required in an emergency, require prior authorization as of 1972. DME, certain dental benefits, amphetamine drugs, weight reduction surgery, surgery of a reconstructive nature and food supplements all require prior authorization. Pre-admission review is conducted for nursing home applicants and periodic level of care reviews for nursing home patients also are conducted. Full time home health care and all admissions to psychiatric hospitals require pre-admission reviews.

Utilization control measures which have been implemented since the inception of the program are disallowance of claims and required identification of the ordering physician on laboratory, x-ray and prescription claims. Monitoring of the hospital discharge planning unit was conducted in the past, but is now being phased out to allow PSROs to take over in this area. Other measures include limitation on length of stay for stays without PSRO approval, patient and provider education, lock in of high users to one physician and requiring participating provider to provide access to medical records.

During 1979 14 providers were suspended from the Medicaid program program and 12 in 1980; in 1979 seven were removed and three in 1980; fines were levied against three in 1979 and two in 1980; and in 1979 jail terms assigned to three and in 1980 to two providers. In regards to clients two were fined in 1979, two received jail terms also in 1979 and one in 1980.

MMIS was implemented in 1976 and in 1970 the state began contracting out for fiscal agent activities.

Total state Medicaid expenditures reached $261.881 million in 1978, $309.569 million in 1979 and $360.0 million in 1980. State expenditures rose from $112.159 million in 1978 to $153.792 million in 1980, while Federal outlays grew from $149.723 million to $206.208 million in those years. Proportionately, the state's contribution to the total was 42.83%, 42.65% and 42.72% in 1978, 1979 and 1980 respectively, while the federal government's share reached 57.17%, 57.35% and 52.28%. Total Medicaid enrollment declined from 286,054 in 1978 to 277,702 in 1979 but increased to 290,000 in 1980. Provider reimbursement rates increased from 1978 to 1980, by 39% from $139.74 to $194.3, by 31.4% for average SNF rates from $26.71 to $35.09 and for ICF rates by 62.4% from $16.45 to $26.71.

To control administrative errors and costs in eligibility determinations, the state undertakes the training of eligibility workers and has proposed error prone profiling and retrieval of Medicaid ID cards from ineligibles. To reduce client errors in eligibility, provider vertification of client identification is required and provider telephone inquiries to the state to determine eligibility status has been implemented. Monitoring of client income through linkages with other employment data files has been proposed. Iowa has implemented a program to recover Medicaid funds from absent parents, and health and casualty insurance.

Total mandatory Medicaid expenditures for inpatient and outpatient hospital services and rural health clinics was $41.134 million in 1979. In the same year SNF expenditures were $1.263 million, physician services totaled $18.151 million and expenditures for optometrists were $1.518 million. Spending for optional benefits was $441,287 for home health, $5.926 million for dental care and $12.031 million for drugs. Total Medicaid expenditures were $15.620 million in 1978, $165.491 in 1979 and $190.412 million in 1980.

Since 1967, the hospital reimbursement system has reimbursed hospitals on an interim basis and, as of 1972, conducted common Medicare and Medicaid audits. Tape to tape billing was implemented in 1979. The nursing home reimbursement system established rate ceilings and implemented submission of a single invoice by a nursing home for all patients in 1973. The state also placed caps on administrative salaries and began imputing a useful life-time of 40 years on nursing homes facilities. In 1974 limits on capital costs were established.

Physician services are reimbursed on the basis of usual, customary and reasonable charges, the latter being updated annually. A plan to monitor PSRO utilization review activities will be implemented in the fall of 1980. Several utilization control measures have been adopted by the state. Starting in 1970 participating providers were required to provide access to medical records, high users are locked in to one physician as of 1976, and patient education was implemented in 1980 along with the required identification of the ordering physician on laboratory, x-ray and prescription claims.

Fines were imposed once against providers in 1979 and 4 times in 1980. A jail sentence was applied once in 1980 against a provider. To improve Medicaid administration all claims processing except ICF was contracted out as of 1967 and a Medicaid Management Information System was implemented in 1979.

In 1979-1980 the ADC cash levels for the categorically needy were increased. For the medically needy, in 1978 the transfer of property provision was discontinued to comply with the SSI provision, and the protected income level was increased from $330 to $360 in 1980.

To control administrative errors or costs in eligibility determinations, consolidation of welfare and Medicaid eligibility applications was implemented and training for and performance monitoring of eligibility determination workers have been proposed. To reduce client errors in eligibility, client income is monitored through linkages with other employment data files and monthly client status reports have been implemented.

A program to recover Medicaid funds from absent parents have been proposed. Programs have already been implemented to recover Medicaid funds from health and casualty insurance, as well as through federal financial participation through retroactive Medicaid eligibility determination.

The Medicaid program was extended in 1979 to cover eyeglasses and dentures, in cases of severe medical hardship, early and periodic screening, and diagnostic testing; personal care (attendant care) was added as a covered service. In 1980, reimbursement for reserve days was reduced to 67 percent and psychiatric hospital stays limited to 21 days. Prior authorization for gastric bypass surgery was initiated in 1980.

The state's hospital reimbursement system as of 1976 began to limit reimbursement rates for services to a rate of the least expensive setting. In 1977, disallowance of weekend admission reimbursement for non-emergency surgery was implemented. The hospital reimbursement system also pays hospitals on an interim basis as of 1975 and conducts common Medicare and Medicaid audits as of 1980. Limiting the age of claims was implemented in 1976 and tape to tape billing in 1978. As of 1974, the nursing home reimbursement system included establishment of a rate ceiling, limits on capital costs, setting limits by cost centers and indexing the reimbursement rate to economic trend factors. In 1974 the state eliminated non-patient related expenses and limits on related party transctions, and placed caps on administrative salaries in 1974.

Physician services are reimbursed on the basis of usual, reasonable and customary charges. Medicare rates are used for the charges which are updated when the budget will allow it. Some procedures were last updated in 1976, others in January and July of 1980. In reimbursing physicians, a limit has been placed since 1975 on the number of billable procedures.

Medicaid reimbursement rates were increased to $30 in 1978 for early and periodic screening and diagnostic testing (EPSDT) with follow-up. In 1980, the reimbursement to physicians for EPSDT with medical home was increased to $40.

There is currently a proposal to reimburse nurse practitioners directly and physician assistants indirectly under the Medicaid Program.

The sample size of the state plan to monitor PSRO utilization review activities will be 20 percent of all claims over the 75th percentile PAS length of stay. At this time, they are reviewed only for length of stay. The Kansas PSRO has 60 days to review the case referred to it by the state. These cases are discussed at a meeting of the state agency and PSRO. Those cases not justified are then reported to the Regional Medicaid Bureau.

Several utilization control measures such as provider education were adopted in 1975. In 1976, disallowance of claims, limitation on length of stays without PSRO approval and lock in of high users to one physician were implemented. Participating providers were required to provide access to medical records in 1977, and identification of ordering physician on laboratory, x-ray and prescription claims was required in 1978.

In 1979, fines were imposed against 7 providers and jail sentences against 7. Six providers were removed from the Medicaid Program in fiscal year 1980. A Medicaid Management Information System was implemented in 1978, and bulk purchasing of eyeglasses was implemented in 1980 and has been proposed for hearing aids.

Total Medicaid enrollment decreased from 1978 to 1980. However, the decrease was not evenly distributed across categories; categorical eligibles decreased while medically needy eligibles increased from 1978 to 1980. Non-Medicaid state general assistance expenditures for medical care was $16.985 million 1978, $16.617 million in 1979 and $18.633 in 1980. The reimbursement rate for hospital rooms rose slightly from $100.91 in 1979 to $104.98 in 1980. Average per day reimbursement for SNF was $20.14 in 1978 and rose to $25.48 in 1980. The ICF rate rose from $14.45 to $19.99 over the same period.

As of July 1, 1980, Kentucky's categorical and medically needy eligibility standards for some Medicaid groups were revised. Specifically, the state increased the Aid to Families with Dependent Children (AFDC) standard of assistance for households with 1, 2, and 3 people. The standard was increased as follows: one person from $75 to $133, two persons from $135 to $162, and three persons from $185 to $188. This change is expected to affect approximately 8,400 persons. The state also increased medical assistance eligibility standards for households of 1, 2, and 3 persons. The standard was increased as follows: one person from $150 to $183, two persons from $183 to $217, and three persons from $250 to $258. Approximately 1600 persons will be affected by the new standards.

To control administrative errors or costs in eligibility determinations, the state implemented in 1966 the consolidation of welfare and Medicaid eligibility applications, trains eligibility determination workers and monitors their performance. Error prone profiling has now been proposed as an additional measure. To reduce client errors, the monitoring of client income through linkages with other employment data files was implemented in 1974, and monthly client status reports has been proposed.

Between 1973 and 1979, Kentucky adopted a series of measures to recover Medicaid funds. In 1973, the state implemented federal financial participation recovery through retroactive Medicaid eligibility determination. Programs to recover funds from health and casualty insurance were implemented in 1978, and in 1979 the recovery program was extended to absent parents, Veteran's Administration, Medicare and CHAMPUS.

Services covered by Kentucky's Medicaid program have been and will be changed between 1979 and 1981, the overall effect of which will be an increase in services covered. The Fiscal Year 1979 service changes are as follows: coverage of complete upper and lower dentures at a cost of $600,000 each fiscal year; coverage of dental sealant as an option to second flouride treatment for patients under 21 years at no additional cost; coverage of second prophylaxis and flouride application per year for age 15-21 group at approximately $40,000; expansion of the outpatient drug list at a cost of $200,000; implementation of a reimbursement system for primary care centers for approximately $1,676,000; and expansion of coverage for takehome supplies through the Home Health program. The outpatient drug list will again be expanded in 1980 for an additional $125,000, while podiatry services will be included for coverage at a cost of $1 million. In calendar year 1980, care in intermediate care facilities for the mentally retarded and developmentally disabled will be expanded to include maintenance care at a yet undetermined cost. Fiscal Year 1981 will see the expansion of coverage for additional diagnostic procedures by optometrists at a cost of $586,432.

State expenditures for mandatory Medicaid benefits increased for virtually all services between 1978 and 1980. Expenditures for inpatient hospital services increased from $55 million in 1978 to $64.3

million in 1979 to $71 million in 1980, a increase of 29.1 percent. Funds for outpatient hospital services and rural health clinics increased from $8.4 million in 1978 to $11.8 million in 1980. Lab and x-ray expenditures declined in 1979, from $160,000 in 1978 to $134,000 in 1979, but rose to $173,000 in 1980. Allocations to skilled nursing facilities rose from $25 million in 1978 to $28 million in 1980. Physician services decreased slightly in 1979, from $28.924 million in 1978 to $28.175 million in 1979. However, in 1980 expenditures surpassed the 1978 level, rising to $31.730 million, an increase of 9.7 percent over the 1978 level and 12.62 percent over the 1979 level. Funds for early and periodic screening and diagnostic testing increased over 100 percent from $411,000 in 1978 to $921,000 in 1980. Funds for family planning rose from $1.057 million in 1978 to $1.163 million in 1980, and for optometrists, expenditures, including eyeglasses, increased from $893,000 in 1978 to $1.298 million in 1980.

Optional benefits such as podiatrists were added in 1980 at a cost of $32,000. Other optional benefits such as home health care rose from $2.321 million in 1978 to $2.8 million in 1979 to $3.597 million in 1980, an increase of 54.97 percent. Funds for general clinic services rose from $1.7 million in 1979 to $2.1 in 1980 and for mental health clinics from $3.8 million in 1978 to $8.1 million in 1980. Dental expenditures rose from $5.8 million in 1978 to $8.6 million in 1980, drugs increased from $12.3 million to $14.8 million, and diagnostic, screening, preventive and rehabilitation services from $38.7 million to $83.7 million over the same time period. Allocation to intermediate care facilities increased from $54.1 million in 1978 to $96.9 million in 1980, while funds for psychiatric hospitalization for those under 21 and over 65 years increased from $1.5 million to $2 million between 1978 and 1980.

The state's hospital reimbursement system includes denial of reimbursement for percentage contracts for laboratory and x-ray services as well as limiting the reimbursement rate for services to the rate of the least expensive setting. Kentucky reimburses on the basis of "Medicare Reasonable Costs." Since 1967, all hospitals have been paid on an interim basis and as of 1975 common Medicare and Medicaid audits are conducted. As of 1980, a limit was placed on the age of claims and reimbursement or a hospital department basis has been proposed.

Since 1975, the state's nursing home reimbursement system has included the establishment of rate ceilings, limiting capital costs, limiting pass through ancillary costs, indexing reimbursement rates to economic trend factors and, in 1976, identical treatment of leased and owned facilities. Physician services are reimbursed on the basis of usual, customary and reasonable charge. For all covered services, physician charges are updated annually and Medicare data, using the consumer price index, are used in the update. From 1975 physician services are reimbursed at the rate where the service was delivered and not from where the service is billed.

Since 1978, Kentucky has adopted some changes in Medicaid reimbursement rates, rate ceilings and co-payments. In 1978, the pharmacy dispensing fee was increased from $1.80 to $2.22 for a total increase of $900,000;inpatient physician fees were increased to 100 percent of first $50 plus 65 percent of the remainder of allowable fee for service for a

total of $33,000; the rate ceiling for intermediate care facilities was raised from $22 to $24; and reimbursement to community mental centers changed from a flat rate of $16.82 per visit to a prospective cost reimbursement system. It is estimated that this measure cost $3.8 million in 1978, $5.9 million in 1979 and $8.2 million in 1980. In 1979, the pharmacy dispensing fee will again be raised from $2.22 to $2.35 at an additional cost of $400,000, while inpatient physician fees will be raised to 70 percent of the remainder of the allowable fee for service at a cost of $55,000. The ICF rate ceiling will again be raised from $24 to $27 per day. The rate for early and periodic screening and diagnostic testing was also increased from $12 to $20 per service. For 1980, fees for dentures were reduced to $250 per complete set. A new usual, reasonable and customary reimburement system was implemented for optometrists and maximum payments for eyeglass materials increased at a total cost of $1.6 million.

Nurse practitioners are not reimbursed through Medicaid. Instead, nurse practitioner services are reimburseable through the Program's Primary Care Center Services element, with payment made to the participating primary care center.

Kentucky is now developing a PSRO monitoring plan to monitor 5 percent of all paid claims and 5 percent of adverse determinations, complimented by trend analysis, and PSRO procedural compliance with state and federal regulations and agency memorandum of understanding. Conflicts between state monitoring and the PSRO will be minimized and/or resolved through regular communications between PSRO and the agency.

Kentucky regulations require that acute hospital, skilled nursing, and basic intermediate care be reviewed by the PSRO, with no other preauthorization required. In calendar year 1979, complete preadmission testing for intermediate care for mentally retarded and developmentally disabled persons was required, the testing to include psychological, social and medical evaluation. The Home Health Section receives copies of the physician's plan of care and recertification for review prior to payment of claims. Equipment items must be authorized prior to payment if the cost exceeds $20.

As of 1966, a number of utilization control measures were adopted, including requiring participating providers to provide access to medical records. In 1968 a process was implemented to monitor potential abuse of procedure codes for extensive physician visits. In 1974 high users were locked in to one physician and in 1980 the disallowance of claims was implemented. Other utilization controls include identification of the ordering physician on laboratory, x-ray and prescription claims, patient education, and a limit of 21 days on all acute admissions. In 1979 the state imposed a fine against one provider and one was suspended from the Medicaid program. The latter sanction was applied once in 1980 against a provider. A Medicaid Management Information System is being implemented in stages between 1979-81.

Total Medicaid expenditures for Kentucky increased from $194.272 million in 1978 to $248.191 million in 1979 to $299.853 million in 1980, an increase of 54.2 percent. The state's share rose from $58.845 million

in 1978 to $95.743 million in 1980, an increase of 62.7 percent, while the federal government's share increased from $135.427 million in 1978 to $204.110 million in 1980, an increase of 50.72 percent. The average monthly Medicaid enrollment decreased from 341,464 in 1978 to 320,265 in 1979 and rose slightly to 327,235 in 1980. The average monthly number of categorical eligibles enrolled decreased from 274,529 in 1978 to 265,908 in 1980 and the number of medically needy from 66,935 to 61,327. Hospital admissions rose from 66,959 in 1978 to 73,062 in 1980 with the average length of stay decreasing from 6.32 days to 6.19 days. The average per day room reimbursement rate rose from $134.17 to $214.31 from 1978 to 1980, an increase of 59.73 percent. Reimbursement rates from 1978 to 1980 for skilled nursing facility rose from $33.83 to $43.48, or 28.53 percent, for intermediate care facility from 19.46 to $24.78 or 27.34 percent, and for home health visit from $22.46 to $26.86, or 19.59 percent.

MAINE

During 1978, 1979 and 1980 the SSI income standard was increased and the AFDC standard increased in 1978 and 1979 only. For the medically needy, income standards were increased in both 1978 and 1979.

To control administrative errors and costs in eligiblity determinations, AFDC eligiblity applications were consolidated with Medicaid applications and SSI applications as of 1974. Training eligibility determination workers and monitoring their performance were implemented in 1966 and as of 1968 Medicaid cards are issued monthly and cards retrieved from ineligibles. To minimize client errors, provider venfication of client identification has been implemented. Monitoring of AFDC client income through linkages with other employment data files has also been accomplished.

As of 1966 Maine has recouped Medicaid funds through federal financial participation in retroactive Medicaid eligibility determination. In 1975 the state implemented a program to recover funds from health and casualty insurance and in 1980 from absent parents. Medicaid coverage was extended to ICF care for the mentally retarded in July 1980, increasing expenditures by $3 million.

Mandatory expenditures for inpatient hospital services increased from $24.306 million in 1978 to $32.036 million in 1979 but declined to $30.079 million in 1980 for an overall increase of 23.75% from 1978 to 1980. Outpatient hospital services and rural health clinic outlays increased from $4.851 million in 1978 to $6.363 million in 1979 but declined to $6.262 million in 1980. Lab and x-ray funds increased from $192,278 in 1978 to $820,805, while SNF increased $2.753 million in 1978 to $3.225 million in 1980. Funding for physician services declined from $13.516 million in 1978 to $12.612 million in 1980, a decline of 7.17%. EPSDT funds increased by 39.1% from $997,242 to $1.387 million in 1980. Family planning funds declined from $732,000 in 1978 to $631,301 in 1979 but increased to $1.601 million in 1980.

Optional funding for medical or other remedial care rose from $2.056 million in 1978 to $3.487 million in 1980 or by 69.6%; home health funds grew 39.55% from $777,482 in 1978 to $1.085 million in 1980. Spending for mental health clinics rose from $144,606 in 1978 to $1.092 million in 1980, an increase of 655%. Dental service funds grew from $1.957 million in 1978 to $2.245 million in 1980. From 1978 to 1980 expenditures for physical, occupation and speech therapy increased from $25,147 to $228,215, drug funds rose from $7.029 million to $7.852 million, and for ICF from $52.736 million to $59.941 million.

The hospital reimbursement system placed a limit on the age of claims in 1974 and instituted common Medicare and Medicaid audits in October 1979. Tape to tape billing has been proposed. In January 1978 the nursing home reimbursement system began setting limits by cost centers, placed caps on administrative salaries and in 1980 began imputing a useful lifetime of 40 years on all nursing home facilities, except wood, that are newly constructed.

Physician services are reimbursed on the basis of a fee schedule that will achieve an annual reduction of 10% in expenditures compared to what expenditures would have been if the Medicare formula is used. As of 1978 reimbursement is also at the rate for service when it was delivered, not billed. Beginning in 1979, Medicaid payments for eyeglasses are based upon the cost of materials.

A state plan to monitor PSRO utilization review activities is being developed utilizing SURS II data. SURS II is a auditing subsystem of the MMIS (which was instituted in 1978) utilizing information from the claims sent by the providers. The information from the claim produces a statistical profile on any provider who deviates from pre-defined criteria for the purpose of analysis and review. Presently, the system uses two standard deviations but there is flexibility with more knowledge regarding hospitals.

Prior to admission in a nursing home, all patients must be reviewed and prior authorized for Medicaid payments as of 1974. Home health plan of care must be submitted for prior approval beyond the assessment visit.

Utilization controls have been adopted beginning with limited patient and provider education in 1974, disallowance of claims and a limitation on the length of stay for stays without PSRO approval in 1975, and a limited lock in of high users to one physician in 1977. Participating providers have had to provide access to medical records as of 1966. Monitoring of discharge planning units have been proposed for FY 1981.

Total Medicaid expenditures rose from $112.053 million in 1978 to $131.896 million in 1980. During that period, state outlays grew from $33.907 million to $40.096 million and the federal outlays from $78.146 million, to $91.8 million. Medicaid enrollment also increased from 98,716 in 1978 to 106,758 with categorically eligibles rising from 91,806 to 96,187 and the medically needy from 6,910 to 10,571. Provider reimbursement rates increased from 1978 to 1980, with the average per day hospital room reimbursement rate increasing 26.1% from $92.00 to $11.00 SNF rates by 12.47% from $49.97 to $56.20 and ICF rates by 26.42% from $25.50 to $33.50.

In 1978, 1979 and 1980 Maryland increased AFDC payments to the categorically eligible by 5 percent, 10 percent and 11 percent, respectively. Payments to the medically needy were changed in July 1978 to $1800 to $2300 for 1 person, $2700 to $2800 for 2 persons, $3200 to $3800 for 3 persons and a new standard of $500 for each additional person. Changes as of July 1979 were $2300 to $2600 for 1 person, $2800 to $3100 for 2 persons, $3800 to $4100 for 4 persons and $500 for each additional person, for an estimated change in enrollment of 10,500. In July 1980 the new standards were $2600 to $2900 for 1 person, $3100 to $3400 for 2 persons, $4100 to $4400 for 4 persons plus $500 for each additional person, resulting in a change in enrollment of approximately 11,000.

To control administrative errors and costs in eligibility determination, the Department of Human Resources has proposed consolidating Welfare and Medicaid eligibility applications as part of an Automated Income Maintenance System and monitoring the performance of eligibilty determination workers. As of 1975, these workers were trained to reduce errors. Retrieval of Medicaid cards from ineligibles is another method adopted by the Medicaid program, although efforts vary by county. A uniform method is currently under study and is being tested by the Department of Human Resources. To minimize client errors the state began providing photo ID in 1973 and plastic cards in 1975 to aid provider vertification of client identification. In 1976 the state implemented provider telephone inquiries to the state to determine eligibility status of hospital inpatients, as well as monitoring of client income through linkages with other employment data files. Monthly client status reports were instituted in 1978 for public assistance only.

Absent parents, health and casualty insurance, workmen's compensation are some of the sources from which the state is trying to recover Medicaid funds. The state also has a program to recover funds through federal financial participation recovery through retroactive Medicaid eligibility determination, as well as through probate and voluntary reimbursements.

Maryland's Medicaid program implemented a day care program in 1980 at an estimated annual cost of $1.5 million, and instituted unlimited psychiatric care at acute general hospitals at an annual cost of $4.5 million and unlimited psychiatric care for persons 65 years or older in psychiatric hospitals for $.16 million each year. In fiscal year 1981, a personal care program will be implemented costing $2.3 million per year. Anoretic agents and central nervous system stimuli will be eliminated in 1981, saving $.225 million.

Medicaid expenditures for mandatory benefits such as inpatient hospital services grew from $117.473 million in 1978, to $169.533 million in 1980. Funds for outpatient hospital services and rural health clinics increased from $26.643 million to $37.820 million. Between 1978 and 1980, lab and x-ray services grew 35.53 percent, from $922,331 to $1.250 million, physician services by 25.22 percent, from $20.604 million to $25.800 million, early and periodic screening and diagnostic testing from $447,310 to $500,000 or 11.78 percent, and optometrist services from $607,475 to $900,000, or 48.15 percent.

Expenditures for optional benefits such as home health care grew 27.54 percent from $618,586 in 1978 to $951,538 in 1980. Dental care funds grew 24.0 percent from 1978 to 1980, or $4.5 million to $5.6 million. Funds for physical, occupational and speech therapy declined from $33,067 in 1978 to $29,470 in 1980, while drugs and dentures, prosthetics, grew 18.88 percent, from $15.241 million to $18.119 million and eyeglasses grew 110 percent, $1.455 million to $3.056 million. Other optional services such as institutionalization for mental diseases for those 65 years and older also increased from 1978 to 1980, from $15.878 million to $20.602 million and for ICF's from $57.441 million to $143.213 million.

As of fiscal year 1977 the hospital reimbursement system imputes an occupancy rate in calculating reimbursement. Reimbursement rates are established by the Health Services Cost Review Commission based on an approved Medicare/Medicaid waiver. Other measures adopted by the system include tape to tape billing as of 1973 for outpatients only, limiting the age of claims as of 1977, and reimbursement on hospital department basis as of 1977. In 1967, the nursing home reimbursement system began to establish rate ceilings, placed caps on administrative salaries, imputed a useful lifetime of 40 years on nursing home facilities, and began to lease and own facilities in identical manners. Indexing of reimbursement rates to economic trend factors was adopted in 1978. Physician service charges are reimbursed on a fee schedule basis, and as of 1967, physician reimbursement has been at the rate for service when it was delivered, not billed. In fiscal year 1981, reimbursement for physician variable fees for home and office visits will be changed at an additional cost of $2.1 million annually. Pharmacy dispensing fees will be increased from $2.55 to $2.95 at a cost of $960,000 annually.

To control utilization, a 14 percent sample of acute hospital invoices are monitored for diagnosis, length of stay, inappropriate or disproportionate procedures, and for excessive use of certain tests. PSROs are notified when questions of length of stay or inappropriate admissions are uncovered and must respond in writing after investigating the situation. A meeting with the executive director of the PSRO can be arranged if conflicts persist.

Prior review and authorization requirements apply to nursing home patients, vision care and to some surgical procedures. Nursing facility patients have been screened and precertified for admission since 1967. Vision care services for examinations and eyeglasses are preauthorized on the basis of one examination and one pair of glasses every two years for those 21 and over and every year for those under 21 since 1976. Certain surgical procedures intestinal bypass and cosmetic surgery - require preauthorization since 1979.

Utilization control measures adopted by the state include disallowance of claims, as of 1967, the requirement that participating providers access to medical records since 1974, and in 1977 monitoring hospital discharge units and changing coverage or reimbursement rate for administrative days to zero. Since 1978, high users are locked in to one physician.

In 1979 the state suspended providers 4 times from the Medicaid program and enforced 1 jail sentence. Five were removed from the program in 1980 and 3 were fined. The number of Medicaid recipients enrolled in prepaid group practices was 30,000 in 1978, 28,000 in 1979 and will be between 26,000 and 27,000 in 1980. Maryland will adopt a Medicaid Management Information System in fiscal year 1981.

In 1978, total Medicaid expenditures were $216.302 million with the state contributing $103.543 million, the federal government $108.301 million and local government $4.458 million. In 1979 and 1980 local government made no contribution, but the state and federal government contributed equally, each contributing $124.112 million and $152.0 million in 1979 and 1980, respectively. From 1978 to 1980 Medicaid expenditures rose 40.54 percent, while Medicaid enrollment changed slightly over the three years with 270,733 categorical eligibles enrolled in 1978 and 270,480 in 1980. Similarly, 45,821 medically needy persons were enrolled in 1978 and 45,690 in 1980. State non-Medicaid general assistance expenditures for medical care rose from $46.515 million in 1978 to $65.0 million in 1980, a rise of 39.74 percent. From 1978 to 1980, the average per day hospital room reimbursement rate rose from $219 to $270, increased the average daily ICF rate increased 24. from $19.35 to $24.00 and a home health visit increased from $23.54 to $28.00. The average rate for an office visit to a nonspecialist physician went from $7 to $9, over the same time period.

For categorically eligibles, cost of living adjustment were instituted in 1979. Assistance was increased for the medically needy in 1979 and 1980, as well as for longterm care cases during the same period. A Personal Care Attendant program was instituted in 1980.

To control administrative errors and costs in eligiblity determinations, training of eligibility determination workers and monitoring of their performance were instituted in 1979. During 1979 policy manual rewrites for AFDC were adopted and will be used for Medicaid in 1980-81. Error prone profiling was also instituted in 19781980 for AFDC recipients and will be implemented in 1980-81 for Medicaid recipients. To reduce client errors, monitoring of client income through linkages with other employment data files and a client response system were implemented in 1978. Provider verification of client identification and provider telephone inquiries to the state as to eligibility status were implemented in 1968. During 198081 a monthly client status report demonstration project will be initiated.

To retrieve Medicaid funds, the state implemented programs to recover funds from casualty insurance in 1968, the Veteran's Administration in 1978, health insurance in 1979 and absent parents in 1980. A Medicaid collections unit also was established in 1978.

Changes in Medicaid covered services during 1979 included: reduced coverage for abortions from all abortions (until 6/78) to state Doyle/ Flynn amendment (7/78) to federal Hyde amendment (8/78) to all medically necessary abortions (8/78) to the present; expansion of the scope of reimbursable drugs for general relief recipients; and age restriction for orthodontic treatment changed from 18 to 21. Additionally a Medication Control Program to prevent a Medicaid recipient from obtaining excessive quantities for prescription drugs through multiple visits to physicians and pharmacies was implemented. Under this program a recipient who has been identified as a "shopper" is issued a Medicaid Eligibility Card that indicates that the recipient may obtain medication from a pharmacy which is responsible for monitoring the recipient's drug utilization. Finally, sterilization and hysterectomy services can only be paid for if the recipient signs a consent form at least 30 days, but no more than 180 days, before the procedure is performed, except in the case of premature delivery and emergency abdominal surgery.

The 1980 changes are: coverage of telephone expenses incurred by recipient in connection with the use of a cardiac packmaker sensor; limits on payment for propoxyphene (Darvon); establishment of time period within which the Medical Division must respond to requests for prior authorization; payment for PGH health assessment when performed by a nurse practitioner; and reimbursement of immediate full upper dentures if certain requirements are met. Personal needs allowance for a Medicaid recipient in longterm care facilities were increased in both 1980 and 1981. The 1981 changes are volume purchasing of eyeglasses and coverage of psychiatric inpatient care for recipients under twentyone.

Mandatory expenditures for inpatient hospital services grew from $163.191 million in 1978 to $212.900 million in 1980. Outpatient hospital services and rural health clinic expenditures rose 24% from 1978 to 1979 and 38.7% from 1979 to 1980, from $46.717 million in 1978 to $59.988 million in 1979 to $64.8 million in 1980. Between 1978 and 1980 other mandatory programs such as lab and x-ray services rose from $2.096 million to $2.578 million, SNF funds from $99.361 million to $146.2 million, physician services from $25.883 million to $40.7 million, and family planning and abortion from $1.420 million to $1.487 million. Optional expenditures also increased from 1978 to 1980 including home health from $9.334 million to $12.286 million, clinic services from $9.579 million to $15.2 million, dental services from $22.581 million to $25.1 million, drugs from $33.735 million to $41.6 million, and ICF from $126.949 million to $140.0 million.

The state hospital reimbursement system began imputing on occupancy rate in 1974 and also disallows any preop stay not deemed medically necessary by the PSRO. Limiting of reimbursement rates for services to the rate of the least expensive setting has been proposed for Fiscal Year 1981. The state has proposed to reimburse hospitals for patients on administrative days status at a rate corresponding to appropriate level of care (e.g., SNF, ICF). Tape to tape billing and a limit on the age of claims also have been implemented. The nursing home reimbursement system, as of 1965, impute an useful lifetime of 40 years on nursing home facilities. In 1975 the states established rate ceilings; reimbursement according to peer grouping; a limit on capital costs and educational, legal, transportation and administrative costs pass-throughs; limits by cost centers and indexing the reimbursement rate to economic trend factors; caps on administrative salaries; and treating leased and owned facilities in an identical manner. Submission of a single invoice for all patients by the nursing home was implemented in 1974. The 1979 changes are incentive for quality of care and accessibility which were revised in 1980. Reimbursement rates were tied to grades of patient disability in 1980.

Physicians are reimbursed on a fee schedule basis and a limit has been placed on the number of billable procedures. Since the beginnning of the Medicaid program, reimbursement has been at rate for service when it was delivered, not billed, and at a rate where service was delivered, not from where service is billed.

Changes were made in Medicaid reimbursement rates and rate ceilings in 1979, 1980 and 1981. The 1979 changes include incentives for high quality care nursing home and for accessiblity of these nursing homes to Medicaid recipients at a cost of $500,000 and $1.3 million, respectively. The 1980 changes are a reduction in payment for hospital patients on administrative day status to correspond to appropriate level of care, and pass through of high nursing costs in longterm care facilities with patients with high levels of disability. From early FY 1979 to until FY 1981, physicians contracted as EPSDT providers have received a special rate when providing EPSDT services; in mid FY 1980 a special rate was also approved for community health centers and family planning agencies contracted as EPSDT providers. The state will cease contracting with providers for EPSDT services in mid FY 1980, but will reimburse any primary care provider at a special rate if they provide EPSDT services and bill according to state regulations.

Physicians assistants and nurse practitioners working in a hospital OPD or community health center are reimbursed directly by Medicaid.

In Massachusetts, PSRO monitoring is accomplished by reviewing a sample of hospital cases which are selected manually from recently paid claims. Sample sizes average between 3% and 4% of total hospital admissions per year, no more than 10% of total admissions. As the state does not have computerized selection criteria, the state focuses on long stays, (over 30 days), psychiatric stays, detoxification stays and administratively necessary days, etc. When there are disagreements on admissions and length of stay, the state informs the PSRO in writing. The PSROs are supposed to explain any discrepancy; however, this happens only in a small percentage of the cases with disagreements. If the state finds that the disagreement level adversely affects the program, the PSRO is given 30 days notice that it is deficient and ultimately a HHS/PSRO/State conference is held to resolve the problem.

For eight elective surgical procedures, Massachussetts requires a mandatory second opinion. During FY 1981 34 additional surgical procedures will be added to the list. Prior screening of ICF and SNF admissions is required where there is no PSRO review. Prior authorization is required for aide service.

Utilization controls which have been adopted include: disallowing claims; requiring participating providers to provide access to medical records; changing reimbursement rate for administrative days in FY 1981 (rates not yet determined); requiring identification of the ordering physician on prescription claims; and, a medication control program for recipients with a large number of pharmacy claims. Provider education for physicians presribing generic drugs has been proposed and monitoring hospital discharge planning units has been implemented on a demonstration basis.

During 1979 a total of seven providers were suspended from the Medicaid program and 26 in 1980. The state does not have the authority to permanently remove providers or to assess fines against them. Restitution and probation were applied against 260 providers in 1979 and 840 in 1980, with restitution totaling $680,000 and $1.2 million in each year.

From 1977 to 1980, Medicaid recipients enrolled in prepaid group practices increased from 1,442 to 4,570. A MMIS has been implemented along with bulk purchasing of goods. Contracting out for services is under consideration.

Medicaid expenditures totaled $645.0 million, $773.0 million and $827.0 million in 1978, 1979 and 1980 respectively. State outlays increased from $312.051 million in 1978, to $399.028 million in 1980, and Federal outlays from $332.949 million to $427.973 million. In each year the state contributed slightly over 48% of the total funds and the federal government over 51%. From 1978 to 1980 total Medicaid enrollment declined from 330,850 to 315,971, categorical enrollment from 249,541 to 246,561, and medically needy enrollment from 81,309 to 69,410. Provider reimbursement rates increased for day hospital room from $202 in 1978 to $247.50 in 1980, while SNF rates rose from $30.58, to $25.0 and ICF from $21.91 to to $25.08. The average rate in a multilevel facility also rose from $28.61 to $32.75 over the same period.

For the categorically eligible and the medically needy, Medicaid need standards were increased in both 1978 and 1979. Beginning in 1979, pre-arranged funeral arrangements were exempt as a resource as the arrangements may be irrevocable. In addition, life insurance for persons over age seventy are excluded as a resource for the medically needy.

To control administrative errors and costs in eligibility determinations, montioring of eligibility determination workers' performance was instituted in 1976 and training of the workers in 1977. A phased implementation of consolidation of welfare and Medicaid eligibility applications was started in 1980. Error prone profiling and an automatic eligibility determination process have been proposed. To reduce client errors a monthly client status report is required for clients with earned income or fluctuating unearned income, and providers are required to check a client's ID care for eligibility. Provider telephone inquiries to the state as to eligibility status also have been implemented. Monitoring of client income through linkages with other employment data files has been proposed.

As of 1972 the state has implemented a program to recover Medicaid funds from health and casualty insurance and through federal financial participation in retroactive Medicaid eligibility determinations. Fund recovery from absent parents has been on effect since 1977, but a new program is now under review by the state to recover funds from absent parents and the Veteran's Administration.

Chiropractic services were eliminated from Medicaid covered services in 1980 at a savings of $1.5 million. In 1978 reimbursement for occupational therapy and speech pathology was administered and expanded.

Manadatory expenditures for inpatient hospital services rose from $259.414 million in 1978 to $378.0 million in 1980, an increase of 45.71%. Funds for outpatient hospital services and rural health clinics declined from $29.471 million in 1978 to $27.0 million in 1980. From 1978 to 1980 lab and x-ray funds rose 21.5% from $10.7 million to $13.0 million, SNF funds by 6.69% from $156.533 million to $167.0 million, physician services by 7.79% from $113.179 million to $122.0 million, and EPSDT funds by 46.22% from $5.608 million to $8.2 million. Family planning funds declined from $7.393 million in 1978 to $7.0 million in 1980. Optional funding for home health care grew from 1978 to 1980 by 81.45% from $1.488 million to $2.7 million, while clinic service funds declined from $694,581 in 1978 to $1.250 million in 1980. From 1978 to 1980 dental funds rose 12.24% from $18.710 million to $21.0 million, drug funds by 20.92% from $53.470 million to $70.0 million and ICF funds by 29% from $196.894 million to $254.0 million.

The state hospital reimbursement system has begun to limit laboratory service reimbursement to high volume, automated lab rate and has implemented disallowance of weekend admission reimbursement for non-emergency services. Limiting reimbursement rate for services to the rate of least expensive setting has been proposed in 1980. The state

reimburses hospitals using a prospective interim rate which does not exceed HCI, and which is cost settled with an opportunity to share savings below the index. As of 1966 reimbursement has been on a hospital department basis and a limit has been placed on the age of claims. Hospitals which participate in the Medicaid Interim Payment System were paid on an interim basis starting in 1972, and tape to tape billing has been implemented. In 1973 a common Medicaid to Medicare audit was instituted and delay of reimbursement as long as federal regulations permit implemented in 1978.

Beginnning in 1973 the nursing home reimbursement system adopted several measures including the establishment of rate ceilings, caps on administrative salaries, an imputed useful lifetime of forty years on nursing home facilities, and identical treatment of leased and owned facilities. In 1978 a limit was placed on capital costs. Submission of a single invoice for all patients by the nursing home was discontinued in 1978. Limits are set by cost centers but in a modified fashion, by combining fixied centers for one limit and variable cost centers for another.

Michigan currently reimburses physician services by paying the lesser of the maximum allowable fee or the actual cost. The state also claims to be under intense federal pressure to adopt Medicare's usual, customary and reasonable charge. They currently use T-18 prevailings as one factor in determining maximum allowable rates. Physician services in Michigan have always been reimbursed at the rate for service when it was delivered, not billed, and at rate where service was delivered, not from where it was billed. Bonuses are granted to physicians for use of less expensive hosptials, outpatient surgery, etc. as of 1977. Per capita payment for each recipient accepted by a physician has been implemented on a demonstration basis. Physicians and nurse practitioners are both reimbursed indirectly by the Medicaid program.

A random sample of 20% of the paid inpatient hospital Medicaid claims is selected for review against the PHDDS 14 elements and the discharge summary for PSRO certification of medical necessity of acute care for admission and length of stay. If questions are raised which require additional information from the patient record to resolve the question, the record is obtained. Professional expertise and appropriate criteria are used to identify eight goals: unnecessary admissions; surgeries; days of stays; preoperative days; post operative days; ancillary services; excessive length of stay due to lack of discharge planning; and lack of preadmission testing. The monitoring process on a case by case basis runs from April 1, 1979 to March 31, 1980.

As a second monitoring technique, overall hospital/PSRO data are developed through the S/UR system. To resolve conflicts betwen state monitoring and PSRO results, the PSRO is given the opportunity to discuss each denied case, etc., which has resulted in any pattern exceeding a threshold nonconfirmation rate (NCR) established for each PSRO. If the PSRO can provide additional supporting documentation to suggest a modification of the state agency denials, the NCR may be adjusted. The development of corrective action plans by the PSRO is expected to address the related patterns of problems exceeding the NCR. All final quarterly and cumulative reports, including patterns exceeding the NCR

for any of the eight goals for each of the ten PSRO, will be shared with the PSRO and the Statewide Council of PSROs prior to release by the Secretary. For the second quarter of calender year 1979, the PSRO approved an average length of stay which the state approved, 5.9 days. They differed in the number of short stay hospita days, the PSRO approving 27.220 and the state approving 26.981.

The following services require prior authorization: speech; hearing aid evaluations, orientations, hearing aids and accessories; eyeglasses; independent diagnostic procedures and specialized vision services; most dental services; shoes; medical supplies, durable medical equipment, prostheses and orthoses; dietary formulas; out of state services; occupational and physical therapy; dental anaesthesiologist (hospital); hemodialysis-back appersonnel (outpatient hospital); and services provided to recipients identified as abuse prone. Selected inpatient surgical procedures require a second opinion.

Utilization controls which have been implemented included requiring participating providers to provide access to medcial records, required idetnfification of the ordering physician on laboratory, x-ray and prescription claims, and lock in of high users to one physician.

During FY 1979 a total of four providers were suspended from the Medicaid program and a fine, criminal jail sentence and restitution ordered by the court or arranged through the prosectutor, each applied against one provider. In 1980 a jail term was assigned to one provider and three were ordered to remit funds to the Medicaid program. A total of twenty-one clients were ordered to remit funds in 1980.

As of June 1, 1978, 1979 and 1980 a total of 66,013, 64,750 and 59,104 Medicaid recipients were enrolled in prepaid group practices. Michigan has developed contracts with five HMOs (with two more soon to be implemented) in high density population areas. Recipients are notified through the mail of the advantages of HMO membership and case workers further explain the advantages of HMO membership and fee-for-service care, and at the time a client applies for Medicaid he/she is allowed a choice. HMOs are developed along a profit incentive line and since the rates are competitive with fee-for-service costs, HMOs are very interested in getting a share of the Medicaid recipient market.

Michigan implemented a MMIS in 1972 and bulk purchasing of good in 1980.

Total Medicaid expenditures, excluding administration, grew form $901.035 million in 1978 to $1,092.2 million in 1980. The state's outlay increased by 35% from $405.466 million, to $547.393 million, and federal outlays grew by 10.95% from $495.569 million, to $549.807 million. Proportionately, the state share of the total in 1978 was 45% and in 1979 and 1980 49.89% while the federal share in 1978 was 55% and in 1979 and 1980 50.11%. Provider reimbursement rate for SNF also increased from $25.75 in 1978 to $29.26 in 1980 and for ICF from $24.64 to $27.89.

MINNESOTA

Three changes were made in Medicaid categorical eligibility programs in 1979; resource limits were increased for couples and singles, real property, used as a home, were made exempt; and, SSA and SSI cost of living increases are disregarded when determining Medicaid eligibility. Changes in 1980 for the medically needy included an increase of income standards and, for disabled recipients, earned income is disregarded. In 1981, personal needs allowance for recipients in long term care facilities will be increased from $30 to $35.

To control administrative errors or costs in eligibility determinations the state implemented training for eligibility determination workers in 1966 and began monitoring their performance in 1974. Retrieval of Medicaid ID cards was instituted in 1975. Consolidation of welfare and Medicaid eligibility applications is under consideration. Measures to reduce client errors have also been adopted by the state, beginning in 1966 with provider verification of client identification, and monthly client status reports was initiated in 1974. Provider inquiries to the county as to eligibility status was adopted in 1978.

As of 1966 the state has sought to recover Medicaid funds through retroactive Medicaid eligibility determination, although this is limited to no more than 3 months prior to the month of application. Funds are also recovered from health and casualty insurance.

Mandatory expenditures of medical assistance only dollars for in patient hospital services grew from $65 million in 1978 to $80.7 million in 1980, for outpatient hospital services from $9.7 million to $11.9 million, SNF from $104 million to $153 million and for physician services from $7.5 million to $8 million over the same period. From 1978 to 1980, optional expenditures, also medical assistance dollars, rose from $1.5 million to $2.6 million for home health care, for clinic services (physicians) from $20.8 million to $25.9 million, for dental services from $9 9 million to $12.1 million, for physical, occupational and speech therapy from $4.4 million to $9.8 million and for ICF from $105.3 million to $136 million.

The state hosital reimbursement system reimburses state institutions at a per diem head rate for services, all of which are provided by the institution. Hospitals are reimbursed on the basis of Medicare reasonable cost. Payment of hospitals on an interim basis and tape to tape billing have been proposed. Since 1974 a limit has been placed on the age of claims and common Medicare and Medicaid audits conducted. In 1974, the nursing home reimbursement system established rate ceilings, placed a limit on capital costs, tied reimbursement rates to grades of patient disability, implemented submission of a single invoice by nursing home for all patients, placed caps on administrative salaries and began inputing a useful lifetime of 40 yeras on nursing home facilities.

Physician services are reimbursed on the basis of usual, customary and reasonable charge. All procedures are reviewed annually and the updates occur over 2 years. Medicare prevailing rates are used as a base, and if those are not available, usual and customary are calculated

from the state's own Medicaid data around the 75th percentile. As of 1974 physician rates have been reimbursed at the rate for service when and where it was delivered. A limit was also placed on the number of billable procedures.

During 1979-80 hospital per-diem (cost settlement) was updated. In 1979, the pharmacy dispensing fee was increased from $2.25 to $3.50, and in 1980 physian services updated from the 1976 base year to the 1978 usual and customary. Both nurse practitioners and physician assistants are reimbursed indirectly by the state Medicaid program.

Minnesota has not yet implemented a formal monitoring plan. The monitoring process will not include sampling, but rather, will review cases identified through the automated post-payment review of hospital providers. A key measure will be length of stay by diagnosis. An exchange of information between the PSRO's and the state agency will be used to resolve conflicts. If the conflict persists, the problem will be referred to the HHS regional office. Prior authorization is required for surgery, procedures or equipment of questionable medical necessity, but deemed advisable.

Minnesota also adopted several utilization control measures in 1974 including disallowance of claims, limitation or length of stay for stays without PSRO approval, requiring participating providers to provide access to medical records, requiring the identification of the ordering physician on laboratory, x-ray and prescription claims, and provider education. Lock in of high users to one physician was implemented in 1976 and drug utilization review in 1978. Three providers were suspended from the Medicaid program in 1979 and 154 and 141 recipients restricted in 1979 and 1980, respectively. One provider was removed from Medicaid, one fined and one assigned a jail term in 1980.

Monthly enrollments in prepaid group practices of Medicaid recipients averaged 396 in 1978, 425 in 1979 and 312 in 1980. HMO enrollment are available to welfare recipients located in certain areas of the state. A MMIS was implemented in 1974.

Total Medicaid expenditures for medical assistance only increased from $405 million in 1978 to $462 million in 1979 to $567 million in 1980, an increase of 40 percent from 1978 to 1980. State outlays rose from $162 million in 1978 to $227 million in 1980. Federal expenditures also rose from $227 million in 1978 to $318 million in 1980.

Numerous changes were made in the standards for the categorically eligible. During 1978, the state extended Medicaid coverage to unborn children, increased the need standard for single individuals in private living arrangements from $130 to $175, decreased the need standard for eligible couples from $300 to $284.10, and increased general disregard on income from $7.50 to $10.00 and on one vehicle per family unit from $300 to $800. Medicaid for disabled minors were also implemented in 1978. Changes in 1979 include consideration of in-kind income in budgeting, increased income standards of individuals in private living arrangements from $175 to $195, and based on a federal court order, stopped attributing income or resources of one spouse to the other or of parents to children. Other 1979 changes include increasing: the disregard on the value of one vehicle per family unit from $800 to $1,500; the maximum allowable tax assessed value of home property from $3,500 to $5,000 for solely owned property and from $6,000 to $8,000 for jointly or commonly owned home property; and the personal needs allowance for nursing home clients from $34 to $44. The above increases also apply to spend-down computations for the medically needy. These measures were adopted in 1979.

Three measures were instituted in 1969 to control administrative errors or costs in eligibility determinations. They include retrieval of Medicaid ID cards from ineligibles, training eligibility determination workers and monitoring their performance. As of 1976, client income is monitored through linkages with other employment data files so as to reduce client errors in eligibility.

Mississippi also instituted programs in 1970 to recover funds from the Veteran's Administration, health and casualty insurance and workman's compensation. Changes in Medicaid covered benefits to be implemented in fiscal year 1981 are a reduction of hospital care from 30 to 20 days and reduction in physician visits from 24 per year to 12 per year.

Expenditures for mandatory benefits such as inpatient hospital services increased 16.2 percent from 1978 to 1980, from $43.339 million in 1978 to $50.228 million in 1980, and outpatient hospital services and rural health clinics increased by 17.44 percent from $5.144 million in 1978 to $6.041 million in 1980. From 1978 to 1980, lab and xray funds rose from $285,401 to $356,200, early and periodic screening and diagnostic testing from $4.540 million to $5.551 million, and optometrist services from $38,768 to $60,500. Family planning expenditures also increased from $1.199 million to $1.4 million in the same period. The largest expenditures were for SNF care and physician services SNF care declined from $50.159 million in 1978 to $48.576 million in 1979, and increased to $55.847 million in 1980. Physician services increased from $16.458 million in 1978 to $21.272 million in 1980.

Optional benefits such as home health care rose between 1978 and 1980 from $400,453 to $650,375, while dental care rose from $1.473 million to $16 million. One of the two largest expenditures was for drugs which declined from $23.725 million in 1978 to $22.341 million in 1980. The other large expenditure item is ICF care, which grew steadily from $16.935 million in 1978 to $29.590 million in 1980.

The state's hospital reimbursement system instituted the disallowance of weekend admission reimbursement for non-emergency services. It also instituted common Medicare and Medicaid audits in 1980, tape to tape billing and a limit on the age of claims in 1978. Ind in 1970, reimbursement on a hospital department basis and the denial of reimbursement for 8.5 percent nursing cost differential were initiated.

Physician services are reimbursed according to a physician fee schedule. In reimbursing physicians the state has imposed a limit on the number of billable procedures, and reimbursement at the rate for service when and where it was delivered. All these measures were begun in 1970.

Changes will be implemented in 1981 for Medicaid rates and copayments. These will include a 50 cents copayment on all prescriptions, which will save the program $3 million each year, a 12 percent increase in dental fees costing $742,500, and the elimination of weekend admissions, which will save $240,000 annually.

In 1970 three utilization control measures were implemented including a requirement that participation providers provide access to medical records, a requirement that identification of the ordering physician accompany laboratory, x-ray and prescription claims, and a lock in of high users to one physician. A Medicaid Management Information System was implemented in July 1979 to enhance program administration.

Total Medicaid expenditures rose from $181.028 million in 1978 to $223.900 million in 1980. The state contributed $42.073 million in 1978, $48.6 million in 1979 and $53.0 million in 1980, a little over 23 percent of the total for each year. Federal government contributions were $138.955 million in 1978, $160.398 million in 1979 and $170.960 million in 1980, or over 76.5 percent each year. In all, state contributions grew 25.97 percent from 1978 to 1980, while the federal government's contribution increased 23.03 percent. Average reimbursement rates per day for a hospital room increased $140.00 to $150.00 from 1978 to 1979 and to $170.00 in 1980.. Average rates per day in an SNF went from $22.17 in 1978 to $25.00 in 1980, and for ICF care from $19.63 to $21.77.

Categorical eligibility changes adopted by Missouri include the treatment of income in which third parties are excluded in 1978, and in 1980 the extension of coverage to an unborn child under Title XIX, and Title XIX coverage of G.M. and services for individuals under the age of sixty-five in state mental hospitals. State standards for the medically needy were changed in 1978 and 1979, beginning with the allocation of income in vendor cases and voluntarily allocating income for dependent maintenance. In May of 1979, the state eliminated income maximums and added an allowable deduction for medical and hospital insurance premiums paid by the claimant when determining vendor surplus. In June of 1979, total property maximums were raised to $20,500. Treatment of third party payments when determining vendor payments and treatment of CETA income for determining maximum for MA cases were changed in July and September, respectively.

To control administrative errors or costs in eligibility determination, monitoring of eligibility determination workers' performance was instituted in 1972 and training in 1975. Consolidation of welfare and Medicaid eligibility applications was implemented in 1980. As of 1967, provider verification of client identification was implemented so as to reduce client errors in eligibility. Monitoring of client income through linkage with other employment data files was adopted in 1978, and a monthly client status report in 1980. Provider telephone inquiries to the state to determine eligibility status also has been implemented.

Missouri has created a program to recover Medicaid funds from health insurance. Coverage under Medicaid was extended in 1979 to durable medical equipment, artificial eyes, pneumovax and sickle cell anemia. During 1980, coverage was extended to second opinions, dental services, hearing aids and podiatry services, optometric services, new physician services and added items to D.M.E. For inpatient hospital care the twenty-one day limit on stay was removed, one day stay was covered and the restriction on non-emergency weekend admission removed. An Ambulatory Surgical Care Center Program was also added in Fiscal Year 1980.

Mandatory Medicaid expenditures for inpatient hospital services declined 16.1 percent from 1979 to 1980, from $71.283 million to $61.398 million. Physician services also declined from $20.803 million in 1979 to $14.383 million in 1980. Family planning funds declined from $1.158 million to $571,000 over the same period. From 1979 to 1980, lab and x-ray expenses grew from $287,568 to $501,171, SNF expenses from $2.708 million to $3.365 million, and outpatient hospital services from $6.199 million to $11.251 million. Spending for optometrists rose sightly from $2.370 million to $2.385 million and early and periodic screening and diagnostic testing from $493,680 to $711,474 over the same period. Optional benefits all increased from 1979 to 1980, including home health care which grew from $534,374 to $561,664, dental care from $7.963 million to $8.305 million, drugs from $20.544 million to $22.157 million, and ICF care from $88.676 million to $100.793 million.

The hospital reimbursement system instituted common Medicare and Medicaid audits in 1979 and a limit on the age of claims in 1980. Several measures were adopted by the nursing home reimbursement system in 1976 including eliminating of the profit factor in reimbursement rates, establishing rate ceilings and reimbursing according to peer groupings. Submission of a single invoice by nursing homes for all patients was implemented in 1979.

Physician services are reimbursed according to a fee schedule. As of 1967, reimbursement is at the rate for service when and where it was delivered, not when and where billed. Reimbursement for office or ambulatory surgery will be at the hospital operating room rate in Fiscal Year 1981. Changes in Medicaid reimbursement rates include an increase in the fee for early and periodic screening and diagnostic testing from $15 to $25 in 1979 and, in 1980, adoption of a common fee schedule for physician services. General practitioner fees were raised to the level of specialists.

Missouri operates under S/URS (Surveillance and Utilization Review System) which monitors all of Title XIX hospital providers. This system also monitors the five PSRO regions for the primary purpose of determining medical necessity and appropriateness of rendered service as to type, level, extent and duration of care. Generally, on a quarterly basis the S/URS unit conducts a 25 percent sampling of inpatients who have received inpatient hospital services. Each of the five PSRO regions are reviewed for coverage, length of stay, billed charges, third party liability and primary and secondary diagnosis.

The state agency is under a Memorandum of Understanding with the five PSRO regions. Within this memorandum the state recognizes the PSRO review of uutilization of inpatient services and is required to reimburse hospital facilities according to the PSRO binding reviews. The state maintains authority for payment based on issue of recipient eligibility, scope of covered benefits and rate of reimbursement. The PSRO and state agency act cooperatively to share information gained by the other party. Through its monitoring, the state agency identifies problems and reports them to the appropriate PSRO region for investigation, resolution and subsequent report of findings. On this same basis, the PSRO regions supply similar information to the state for appropriate resolution. Additionally, the state Medicaid agency meets quarterly to review developments and discuss problems and issues in the eventual review of inpatient care.

Prior to March 1, 1980, the Missouri Title XIX program did not allow one-day stays. This program limitation was generally based on specific diagnosis. With the implementation of the MMIS program as of August 1, 1979, the control of short stay hospital days was decreased, a measure eventually resulting in the deletion of one-day inpatient limitation. To date, with the efforts put forth by the PSRO region and S/URS controls, very few admissions of short stays not appropriate to the diagnostic need of the patient are reflected in the data.

Current federal guidelines are met in regard to abortions and other medical procedures in relation to second opinions for elective surgeries. Medical services such as Home Health Services require plans of care, dentures for nursing home patients require certification, and

denture replacements require prior authorization. Diagnostic services from physicians' offices or outpatient facilities, if provided in relation to hospitalization, are not covered if duplicated unnecessarily upon admission. Such polices have been functional since 1972. Home Health Services which require prior authorization are: replacement of a standard hospital bed; purchase, rental or replacement of electric hospital bed; replacement of alternating pressure pad; wheelchair attachments and accessories; patient lifts; and oxygen equipment. Replacement of lower extremity and spinal braces, and artificial legs and arms also require prior authorization. Procedures such as blepharoplasty, heart and kidney transplants, rhinoplasty, reduction mammoplasty for alleviation of severe back pain and surgical reconstruction for correction of congenital anomalies or visible disfigurement resulting from a traumatic injury all require prior authorization.

Implementation of the following utilization control measures were implemented in 1967: monitoring hospital discharge planning units; disallowing claims; limiting length of stays for stays without PSRO approval; requiring that participating providers give access to medical records; and identifying ordering physicians on laboratory, x-ray and prescription claims. A lock in of high users to one physician and provider education were also adopted in 1972 and 1979, respectively.

During 1979, seven providers were suspended from the Medicaid program and nine in 1980. Three providers were removed from Medicaid in 1979 and four in 1980. Fines against providers totaled $16,000 in 1979 and $44,500 in 1980. Jail sentences of two years were applied to providers in 1979 and terms of six years in 1980. No sanctions were applied against clients in either year. A Medicaid Management Information System was implemented in 1979, in addition to the contracting out of claims processing.

Unlike most other states, total Medicaid expenditures declined 4.72 percent from $228.332 million in 1978 to $218.033 million in 1980. The State outlay in 1979 was $89.464 million or 39.18 percent of the total, and in 1980, $89.713 million or 40.23 percent of the total. The federal share was 60.23 percent or $138.868 million and $130.320 million or 59.79 percent in 1979 and 1980, respectively. Total Medicaid enrollment remained constant at 450,000 in both years. During the same two years the average per day hospital room reimbursement rate rose from $101 to $144 while the average non-specialist physician rate per office visit grew slightly from $8.88 to $8.92. The average SNF rate increased from $15.76 in 1978 to $27.23 in 1980, and the ICF rate from $15.67 to $20.14. The average rate per home health care visit increase from $20.38 in 1979 to $22.04 in 1980.

To control administrative errors or costs in eligibility determinations, the state consolidated welfare and Medicaid eligibility applications in 1972 and began training eligibility determination workers in 1967. Provider telephone inquiries to the state as to eligibility status were adopted in 1976 and monthly client status reports in 1980. Error prone profiling and monitoring of client income through linkages with other employment data files have been proposed.

Since 1972, the state has implemented a program to recover Medicaid funds from the Veteran's Administration, from health and causalty insurance in 1977 and from absent parents in 1979. Reductions in Medicaid covered services have been proposed in the legislature but have been defeated.

Mandatory Medicaid expenditures for inpatient hospital services increased from $9.129 million in 1978 to $11.957 in 1980, an increase of 30.9%. Other large mandatory expenditures for physician services increased from $5.469 million in 1978 to $6.317 in 1980, or 15.49 percent, and for outpatient hospital services and rural health clinics from 1.0 million to $1.187 million over the same period. Expenditures for SNF care declined from $3.813 million in 1978 to $2.1 million in 1980. Family planning expenditures also declined from $166,695 in 1978 to $151,200 in 1980.

Optional benefits for medical or other remedial care grew slightly from $278,167 in 1978 to $285,046 in 1980, and home health funds rose from $189,230 to $270,521. Mental health clinic spending declined 18.1 percent from $309,234 in 1978 to $261,867 in 1980. From 1978 to 1980 funds for dental care increased from $1.439 million to $1.747 million, drugs rose from $2.359 million to $2.850 million, and ICF care increased from $21.845 million to $29.791 million.

In 1967 common Medicare and Medicaid audits were instituted. A limit was placed on the age of claims in 1976 by the hospital reimbursement system. The state's nursing home reimbursement system has implemented several measures over the years beginning with a limit on capital costs, submission of a single invoice by nursing homes for all patients and caps on administrative salaries. In 1978 rate ceilings were established, a useful lifetime of 40 years was imputed to nursing home facilities and indexing of reimbursement rates to economic trend factors begun. The elimination of profit factor from the reimbursement rate was instituted in 1979. Measures which have been proposed but not yet implemented include tying reimbursement rates to grades of patient disability, setting limits by cost centers and identical treatment of leased and owned facilities.

Physician services are reimbursed on the basis of usual, customary and reasonable charges. These charges are updated based on Medicare procedures and policies. Since 1967, reimbursement of physicians is at the rate for service when it is delivered, not billed.

Several utilization control measures have been adopted by the state beginning in 1967 with the requirement that participating providers provide access to medical records. In 1974, identification of the ordering physician was required to accompany laboratory x-ray and prescription claims. Patient and provider education was instituted in 1976 and lock in of high users to one physician in 1979. Disallowance of claims also has been implemented.

Four providers were suspended from the Medicaid program in 1979 and one in 1980. No sanctions were applied against clients. In 1974 a Medicaid Management Information System was implemented.

In 1979, the Medicaid eligibility standards were changed to consider the income of the ineligible spouse of a client in a care facility and will affect an estimated 50 persons annually. The income standards were also increased in 1979 and 1980, resulting in enrollment growth of 500 and 1000 persons each. For the medically needy, the disregarded income for an individual in a long term care was increased in 1978 and in 1979. There was a change in the definition of retroactive and prospective eligibility. Both provisions were estimated to affect 50 persons each.

Several measures were implemented to control administrative errors and costs in elibibility determinations. These include error prone profiling, consolidation of Welfare and Medicaid eligibility applications, retrieval of Medicaid ID cards, the training of eligibility determination workers and the monitoring of their performance. Measures to reduce client errors were also adopted and include monthly client status reports, provider verification of client identification and provider telephone inquiries to the state to determine eligibility status. In one county, Douglas county, photo ID's have been instituted. One proposal which has not yet been implemented is the monitoring of client income through linkages with other employment data files.

The state has also initiated a program to recover Medicaid funds from health and casualty insurance and through federal financial participation in retroactive Medicaid eligibility determination. Other proposed sources of fund recovery are absent parents and the Veteran's Administration.

Some of the mandatory Medicaid benefits showed increases and decreases in expenditures during the 1978-1980 period. Inpatient hospital services rose from $16.1 million in 1978 to $23.6 million in 1980. Outpatient hospital services grew from $1.9 million in 1978 to $2.4 million in 1980, or by 26.3 percent. Rural health clinics received $4,788 in 1980 but received no funds in 1978 and 1979. Funds for lab and x-ray services stayed at approximately $1.8 million in 1978 and 1979 but declined to $621,000 in 1980. SNF expenditures rose 14.6 percent from 1978 to 1979, from $4.8 million to $5.5 million, and increased 7.3 percent from 1979 to 1980, to $5.9 million. Physician services also rose steadily from 1978 to 1980, $5.5 million to $7.1 million, an increase of 29.1 percent for the period. Expenditures for early and periodic screening and diagnostic testing declined from $208,091 in 1978 to $200,347 in 1979 and then rose to $212,808 in 1980. Family planning also had a similar pattern declining from $352,276 in 1978 to $311,007 in 1979 and then rising to $362,560 in 1980.

Optional benefits for medical or other remedial care declined 27.9 percent from 1978 to 1980 from $631,959 to $494,106. Home health care benefits rose from $431,991 in 1978 to $704,152 in 1980. From 1978 to 1980, clinic services increased from $1.1 million to 1.5 million, dental services from $1.5 million to $1.7 million, and drugs from $6.3 million to $7.9 million. Funds for ICF care for MR and NMR also increased during 1978-1980 period from $43.5 million to $54.8 million.

The state's hospital reimbursement system proposed and adopted several measures to control reimbursement costs. Denial of reimbursement for percentage contracts for laboratory and x-ray services has been proposed. The disallowance of weekend admission reimbursement for non-emergency services, as well as limiting the reimbursement rate for services to a rate of least expensive setting, have been adopted. Since 1969, the state has paid all hospitals on an interim basis, instituted common Medicare and Medicaid audits and the denial of reimbursement for 8.5 percent nursing cost differential. As of 1979 reimbursement has been on the basis of hospital department charges. Other measures adopted are tape to tape billing and a limit on the age of claims. Several measures have also been implemented by the state's nursing home reimbursement system in 1976. They are: the establishment of rate ceilings; reimbursement according to peer grouping; caps on administrative salaries; imputing a useful life time of 40 years on nursing home facilities; and identical treatment of leased and owned facilities. Indexing the reimbursement rate to economic trend factors, for return on equity only, also has been implemented. One proposed measure not yet implemented is the tying of reimbursement rates to grades of patient disability.

Physician services are reimbursed according to the usual, customary and reasonable charges which are updated annually per the Medicaid usual and customary rate and the prevailing area rate. Reimbursement to physicians is also at the rate where the service was delivered and not from where the service is billed.

In regards to prior review and authorization for medical care, a Medicaid recipient must be certified as appropriate for nursing home care by a medical review team in order for such care to be reimbursed by Medicaid. Continued care is certified by the Medical Review Team during annual onsite reviews and six-month utilization reviews. When a client has been certified for nursing home care, an MC9 prior authorization document is submitted by the county with financial responsibility to initiate computerized payment approval. Clients have been certified for nursing home care since the beginning of the nursing home program. The computerized payment prior authorization was implemented in 1974.

Between 1972 and 1980 several utilization control measures were implemented by in the Nebraska Medicaid program, beginning with lock in of high users to one physician in 1970. Provider education and the requirement that participating providers give access to medical records began in 1972. In 1974 the identification of the ordering physician was required on laboratory, x-ray and prescription claims; the disallowance of claims was also instituted. As of 1980, monitoring of hospital discharge planning units was begun. A Medicaid Management Information System was implemented between 1974, and bulk purchasing of goods was proposed in 1980.

Since 1978 total Medicaid expenditures rose from $84.567 million to $108.024 million in 1980. State contributions to the total was $22.444 million in 1978, $25.039 million in 1979 and $25.818 million in 1980, or 26.54 percent in both 1978 and 1979 and 23.9 percent in 1980. The federal contribution over the same three years was $45.210 million, $50.437 million and $64.706 million or 53.46 percent in both 1978 and

1979 and 59.9 percent in 1980. The local share was $16.913 million, $18.869 million and $17.500 million in those years. Total Medicaid enrollment declined from 129,117 in 1978 to 120,851 in 1979 and then grew slightly to 122,653 in 1980. Categorical eligibles grew from 110,747 to 102,026 while the number of medically needy grew from 18,370 to 20,627 over the same period. Non-Medicaid state general assistance expenditures for Medicaid care rose from $604,050 in 1978 and $1.297 million in 1980. From 1978 to 1979, the average per day hospital room reimburement rate rose from $201.21 to $223.94, the average non-specialist physician rate per office visit from $9.46 to $9.94, and the average SNF rate $21.72 to $26.41. The ICF care rate for the mentally retarded increased from $32.15 to $37.90 and for general ICF care from $13.01 to $15.25 from 1978 to 1979. The average home health visit rate declined from $10.22 in 1978 to $9.75 in 1979 and rose again to $11.45 in 1980.

For the categorically needy, Medicaid standards for eligibility were changed in 1979 and 1980. Income standards for persons residing in Title XIX medical institions were increased in both years and is estimated to have affected 30 to 40 persons each year.

For purpose of controlling administrative errors or costs in eligibility, all cases are considered error prone and reviewed 100 percent; Medicaid cards are issued for a 1 month period only. As of 1969, eligibility determination workers have been trained and their performance monitored. To reduce client errors in eligibility, provider vertification of client identification is implemented when a client does not have the ID cards in his or her possession. Monitoring of client income through linkages with other employment data files and monthly status reports were adopted in 1970, and in 1973 provider telephone inquiries to the state to determine eligibility status was required.

Nevada employs cost-avoidance instead of recovery, and providers must bill other insurancers first. A computer edits and rejects claims which have no other paid indicated. These other sources include absent parents, the Veteran's Administration, health and casualty insurance. The state currently is working to establish subrogation procedures for claims missed in editing process. In addition, Nevada always has collected funds through federal financial participation in retroactive Medicaid eligibility determination.

No Medicaid services have been added or deleted since June 30, 1978 and all changes in reimbursement rates, rate ceilings and/or copayments have been made to accomodate inflation.

Mandatory Medicaid benefits generally have increased between 1978 and 1980. Expenditures for inpatient hospital service grew from $6.772 million in 1978, to $11.401 million in 1980, and physician services from $2.688 million to $3.863 million. SNF expenditures, however, declined over the same period from $6.336 million to $821,159. From 1978 to 1980, outpatient hospital services and rural health clinic funds grew from $655,305 to $823,930, lab and x-ray from $57,995 to $82,538, early and periodic screening and diagnostic testing from $110,290 to $184,567, and optometrist services from $91,010 to $131,306.

Optional benefits such as medical or other remedial care including ambulance, private transportation, ambulatory surgical center, chiropractor and podiatry also increased from $178,159 in 1978 to $395,185 in 1980. Other optional benefits which increased from 1978 to 1980 include: home health care, from $132,440 to $266,924; dental services from $351,703 to $594,258; and dentures, prosthetics and eyeglasses from $88,778 to $247,573. Over the same period other large increases occured in expenditures for physical, occupational and speech therapy, which rose from $9,274 to $175,565, and for ICF and MR care which rose from $5.1 million to $18.473 million. The decline in SNF use and expenditures was seemingly compensated for in ICF utilization. Drug funds also rose from $1.019 million to $1.635 million.

The Nevada hospital reimbursement system is reviewing the denial of reimbursement for percentage contracts for laboratory and x-ray services

and has proposed limiting laboratory services reimbursement to a high volume, automated lab rate for outpatient services. Disallowance of weekend admission reimbursement for non-emergency services is included in a Memorandum of Understanding with Nevada PSROs, which determines whether an emergency exists. Limiting the reimbursement rate for services to a rate of least expensive setting has been proposed. Nevada also reimburses on the basis of Medicare reasonable costs. Common Medicare and Medicaid audits were begun in 1979 and a limit placed on the age of claims. Tape to tape billing has been proposed and payment of all hospitals on an interim basis is under review. The state's nursing home reimbursement system adopted several measures in 1972 including: a profit factor in the reimbursement rate; establishment of rate ceilings; a limit on capital costs; setting limits by cost centers; caps on administrative salaries; imputing a useful lifetime of 40 years on nursing home facilities; and, the identical treatment of leased and owned facilities. In 1976, efficiency incentives were eliminated. The indexing of reimbursement rates to economic trend factors has also been implemented. Physician services are reimbursed on a fee schedule basis based on the 1974 CRVS. Reimbursement is at the rate for service when it was delivered, not billed as of 1970. Nurse practitioners and physician assistants are reimbursed by Medicaid, with the former being reimbursed directly and the latter indirectly.

The state plan for monitoring PSRO utilization review activities includes a random selection of 385 cases, approximately 20 percent of total cases. Key measures include appropriateness of admission, length of stay and appropriate certification for administrative days. The state has delegated review of admission for SAMI hospital benefits to PSROs. To resolve conflicts between state monitoring and PSRO results, the state's Medicaid and PSRO staffs meet to review differences. If not resolved, the State Medical Association will assist in locating a physician who will review the case or cases. The physician's decision is binding on both agencies.

All hospital admissions, except emergency cases, require preadmission review by a PSRO physician advisor. Outpatient Medical procedures provided by a physican require no prior review if done within the 2 physician visits per month limitation. Other services such as therapy require prior approval. Inpatient procedures are subject to PSRO review and state monitoring. The state is working with PSROs to identify certain medical procedures which will be subject to MCE studies. The results will affect Medicaid coverage. Prior to approval for payment for long term care, the LTC facility must submit a form on each patient to the Control and District offices. The form contains the following: 1) medical evaluation with certification for a specific level of care completed by the attending physician; 2) nursing evaluation and completed patient care completed by the Director of Nurses or designated nurse; and 3) social service and activities assessment and plan completed by facility social worker and activities director. The district staff office verifies the information through on-site reviews. The central office reviews compiled information and approves payment. This procedure has been in effect since January, 1977.

Prior authorization for the Home Personal Care Program, based on patient needs, is sent to providers monthly. Services needed are identified in the Nursing Care plan, which is written following an initial patient

assessment, and then updated quarterly or as the patient's condition changes. Completed invoices are returned to the Medical Care Unit at the end of each billing period, reviewed by the program coordinator, and forwarded to the fiscal intermediary for payment. Home health agencies must submit a request for care accompanied by a Nursing Care Plan to justify the need for requested services.

Utilization controls adopted by the state include disallowance of claims and provider education in 1968, and in 1979 the required identification of the ordering physician on laboratory, x-ray and prescription claims. Participating providers are required to provide access to medical records, and high users are placed on an Emergency Care Only/Prior Authorization Program. Patient education is under review and one hospital's discharge planning unit is proposed for monitoring.

Two providers were suspended from the Medicaid program in both 1979 and 1980 and $2000 in fines collected in 1980 from providers. The Pharmacy Board has also taken action against a pharmacy. As of 1968, Medicaid has contracted out for all claims processing and will implement a Medicaid Management Information System between 1981 and 1982.

Total Medicaid expenditures have increased from $23.999 million in 1978 to $40.906 million in 1980. Contributions were divided equally between the state and federal government each year. Categorical Medicaid enrollment declined from 18,112 in 1978 to 17,719 in 1979 and then increased to 19,509 in 1980. The average per day hospital room reimbursement rate also rose from $162.35 to $181.14, or 11.57 percent from 1978 to 1979, while the average non-specialist physician rate per office visit remained the same at $13.25 in both years. The average SNF rate rose from $25.37 to $37.27, or 23.26 percent, and the ICF rate from $23.41 to $29.55 or 26.23 percent from 1978 to 1980.

NEW HAMPSHIRE

The categorical eligibility, need standards were increased in 1978, 1979 and 1980 for the aged, blind and disabled, and the CAP was increased to the maximum in 1978 and 1979. Medicaid coverage was extended to adoption subsidy cases in 1978 and AFDC need standard increased in 1979. For the medically needy the protected income level was increased in 1979.

Several measures have been implemented to control administrative errors or costs in eligibility determinations. In 1973 training of eligibility determination workers and monitoring of their performance began. Consolidation of Welfare and Medicaid eligibility applications have been standard procedure since 1967. Medicaid cards are issued monthly so as to minimize abuse. Error prone profiling has also been proposed. To reduce client errors, a personal pickup for the first AFDC check has been required since 1974 until the absent parent has been gone for 30 days. As of 1975 all recipients were required to report every 6 months to the local office for check pick up. Monitoring of client income through linkages with other employment data files has been proposed.

In 1971 the state implemented a program to recover Medicaid funds from absent parents, the Veteran's Administration, health and casualty insurance, and in 1978 from federal financial participation recovery through retroactive Medicaid eligibility determination. As of 1978 there were no changes in Medicaid benefits in New Hampshire.

Expenditures for mandatory benefits such as inpatient hospital service rose from $8.500 million in 1978 to $10.497 million in 1980, while outpatient hospital services expenditures increased from $1.358 million to $1.921 million. Funds for physician services declined from $3.919 million to $3.795 million. Optional benefits such as home health rose from $498,880 to $671,839 from 1978 to 1980. Over the same period, dental care funds declined from $716,121 to $637,168 and drug costs increased from $2.8 million to $3.054 million.

Common Medicare and Medicaid audits have been conducted by the hospital reimbursement system since 1975 and the age of claims limited since 1972. Tape to tape billing has also been proposed. In 1977, the nursing home reimbursement system adopted the elimination of the profit factor in reimbursement rates, established rate ceilings and reimbursement according to peer grouping, set limits by cost centers, indexed the reimbursement rate to economic trend factors, placed caps on administrative salaries, and treated leased and owned facilities in the identical manner.

Physician services are reimbursed on a fee schedule and, as of 1972, reimbursement is at the rate for service when and where it is delivered. During 1978 and 1979, Medicaid's reimbursement rate and rate ceilings were changed. In 1978 the professional fee for pharmacy providers was raised from $2.20 to $2.70. The series of changes adopted in 1979 included changing physician rates from fee profiles to fee schedules family planning clinic rates, and increasing to 25 percent the incentive

to ICFs for cost containment. Finally, the $500 limit for two mental health center procedures, partial hospitalization and for clients with chronic problems, was eliminated.

Nurse practitioners and physician assistants are reimbursed if they are directly supervised by an MD or if they work in a rural health clinic.

Between 1967 and 1980 several utilization control measures were adopted. In 1967, provider education, disallowance of claims and the requirement that providers provide access to medical records was instituted. Identification of the ordering physician on laboratory, x-ray and prescription claims was required in 1974, and in 1978 hospital discharge planning units were monitored and overstays reviewed on a case by case basis. Limitations on length of stay without PSRO approval and a 14 day overstay limit have been proposed for 1980. Since 1973 a Medicaid Management Information System has been operating in New Hampshire, as has the contracting out of Medicaid dental services.

Total Medicaid expenditures for fiscal years 1978, 1979 and 1980 are $49.766 million, $59.320 million and $70.0 million, respectively. The state's share rose from $14.831 million in 1978 to $19.315 million in 1980, while the federal share increased from $30.755 million to $43.085 million. The local share of the Medicaid bill grew from $4.180 million to $7.6 million from 1978 to 1980. In 1978 the federal government contributed 61.80 percent to the total Medicaid expenditures, state government 29.80 percent and local government 8.4 percent. In 1980 these proportions were 61.55 percent federal, 27.59 percent state and 10.86 percent local. Although Medicaid costs increased, Medicaid enrollment declined from 37,479 in 1978 to 33,800 in 1980. Categorical eligibles decreased from 33,064 to 31,250 and medically needy from 4,415 to 2,550. NonMedicaid state general assistance expenditures for medical care was $178,000 in 1978 and grew to $192,000 in 1980.

During 1978, 1979 and 1980 Medicaid standards for the categorically eligible AFDC recipients were increased along with the SSI/Medicaid only standards. The legally responsible relative schedule was also updated in 1979.

To control administrative errors and costs in eligibility determination, the state consolidated welfare and Medicaid eligibility applications in 1970 and began training eligibility determination workers. Retrieval of Medicaid ID cards from ineligibles was implemented in 1974 for the SSI population and in 1980 for the DYFS population. The state instituted provider verification of client identification and provider telephone inquiries to the state as to eligibility status in 1970. Photo IDs were implemented for AFDC and food stamp recipients in 1979. The state proposed in 1979 the implementation of monitoring client income through linkages with the IRS and state income tax data files.

Programs to recover Medicaid funds from the Veteran's Administration, health and casualty insurance and from responsible relatives, fraud and abuse, probate and other forms of third party liability were all implemented in 1970. Recovery of funds through federal financial participation in retroactive Medicaid eligibility determination began in 1973.

Changes in Medicaid covered services included a reduction in outpatient hospital reimbursements to 60 percent of charges, resulting in savings of $4.0 million in 1980, and in 1981 the inclusion of personal care services in home health at a cost of $4.4 million.

Mandatory Medicaid expenditures for inpatient hospital services rose 21.3 percent from $133.6 million in 1978 to $162.0 million in 1980, while outpatient hospital services and rural health clinic funds rose 19.2 percent from $34.4 million to $14.0 million. Funding from 1978 to 1980 for lab and x-rays rose from $1.6 million to $2.0 million, for SMF from $7.7 million to $13.0 million, and for physician services from $52.7 million to $56.0 million. EPSDT funds grew from $981,465 in 1978 to $1.02 million in 1979, but declined slightly to $1 million in 1980. Family planning funds declined from $2.9 million in 1978 to $2.6 million in 1979 before increasing to $5 in 1980. Outlays for optometrist declined from $2.3 million in 1978 to $2 million in 1980.

Funding also rose from 1978 to 1980 for Optional Medicaid expenditures; medical and other remedial care from $12.4 million to $16.0 million, from $3.8 million to $9 million for home health, from $4 to $5 million for clinic services, from $3.8 to $4 million for dentures, prostheses and eyeglasses' and from $4.6 to $6 million for psychiatric hospitalization for those under 21 yeras. Large optional expenditures also increased from 1978 to 1980. Spending for dental services grew from $21 to $22 million, for drugs from $34.1 million to $43 million from $31.2 million to $42 million for insitution for mental diseases for those 65 and older, and from $155.6 million to $294 million for ICF.

Hospitals in New Jersey are reimbursed based on the Standard Hospital Accounting and Rate Evaluation System. Since 1970 the hospital reimbursement system has paid all hospitals on an interim basis, conducted common Medicare and Medicaid audits, and implemented denial of reimbursement for 8.5 percent nursing cost differential. Tape to tape billing was instituted in 1972 and a limit placed on the age of claims in 1977. The nursing home reimbursement system instituted submission of a single invoice by nursing home for all patients, began indexing the reimbursement rate to economic trend factors and imputing a useful lifetime of 40 years on nursing home facilities in 1970. As of 1974 reimbursement rates have been tied to grades of patient disability, and in 1976 limits were set by cost centers. During 1978 identical treatment of leased and owned facilities was instituted, a limit place on capital costs and pass throughs disallowed with all costs being tested for reasonableness. Caps have been placed on administrative salaries in 1970, 1976 and 1980.

Physician services are reimbursed according to a fee schedule. Reimbursement of physicians is at the rate at when and where the service was delivered. Claims which are selected for state review will include stays exceeding the authorized number of days, any stay of one day, preoperative periods in excess of 48 hours, inpatient stays which could have been performed on an outpatient basis, charges not consistent with diagnosis, elective cosmetic surgery, etc. The sample size will be 20 percent. The length of stay approved by the PSRO and the state in 1978 averaged 20.0 vs. 11.9 in 1979, 13.2 vs. 7.8 and in 1980, 17.62 vs. 7.92. The number of short stay hospital days approved by the PSRO and the number which would have been approved by the state average 1740 vs. 1033 in 1978, 1484 vs. 876 in 1979 and 1885 vs. 847 in 1980. Services requiring prior authorization include psychiatric services in excess of $300 in any one year, cosmetic surgery and home health care.

Several utilization control measures were implemented in 1970 including disallowance of claims, limitation on length of stay for stays without PSRO approval, patient and provider education and the requirement that participating providers provide access to medical records. As of 1978 the identification of the ordering physician is required on laboratory, x-ray and prescription claims. Lock in of high users to one physician was implemented in 1980.

During 1979 11 providers were suspended from Medicaid and 32 in 1980, twelve were removed in 1979 and eight in 1980. Fines were assessed against ten in 1979 and one in 1980, while jail terms were assigned to twelve in 1979 and one in 1980. A total of $773, 475 was recovered in 1979 and $279,384 in 1980. In addition to false claims, errors in payments and billings also contributed to the fund recovery. New Jersey Medicaid began contracting out for claims processing and provider enrollment in 1970 and implemented a MMIS system in 1973.

Total Medicaid enrollment rose form $516.185 million in 1978 to to $725,961 million in 1980. State expenditures rose from $260.673 million to $366.610 million or 40.65 percent from 1978 to 1980. Federal outlays rose from $255.512 million to $359.351 million or 40.64 percent from 1978 to 1980. Proportionately, the state contributed 50.5 percent of the total each year and the federal government 49.5 percent. The number of categorical eligibles declined from 637,519 in 1978 to 629,400 in

1980. Non-Medicaid state general assistance expenditures for medical care was approximately $13 million annually from 1978 to 1980. Provider reimbursement rates also increased from 1978 to 1980, from $94.74 to $119.84 for average per day hospital room reimbursement rate, from $12.13 to $12.95 for non-specialist physician office visits, from $30.12 to $35.12 percent for SMF, from $23.55 to $27.29 for ICF, and $21.57 to $25.15 for average home health visits.

In 1979 and 1980, the maximum income for the nursing home program was raised from $370 to $568.20 and from $568.20 to $650, respectively. These changes were made for the categorically eligible.

To control administrative errors or costs in eligibility determination, Medicaid and welfare eligibility applications are consolidated, Medicaid cards are issued monthly, and eligibility determination workers are trained and their performance monitored. Measures to reduce client errors in eligibility include provider verification of client identification and provider telephone inquiries to the state as to eligibility determination. The state has implemented a plan to recover funds from absent parents, health and casualty insurors.

Mandatory benefits for inpatient hospital services rose from $14.566 million in 1978 to $17.499 million in 1980. The second largest mandatory expenditure was for physician services which rose 35.94 percent from 1978 to 1980, from $7.243 million to $9.846 million. During the 1978-1980 period outpatient hospital services and rural health clinics funds increased from $1.808 million to $4.338 million, lab and x-ray funds declined from $1.024 million to $265,000, while SNF funds rose from $551,000 to $948,000. Other mandatory service expenditures such as early and periodic screening and diagnostic testing rose from $315,000 to $529,000, family planning rose from $96,000 to $210,000 and optometrists fees, including eyeglasses, increased from $318,000 to $390,000.

Optional benefits such as home health care grew from $210,000 in 1978 to $417,000 in 1980. Funds for services in general clinic declined from $2.543 million to $17,000, but mental health clinic services funds increased from $195,000 to $248,000. From 1978 to 1980, dental care funds rose from $1.5 million in 1978 to $1.9 million in 1980; funds for physical, occupational and speech therapy rose from $95,000 to $128,000 and drug funds from $4.5 to $4.8 million.

The state's hospital reimbursement system has proposed denial of reimbursement for percentage contracts for laboratory and x-ray services. In 1977 a limit on reimbursement rates for services set at rates for "least expensive setting" was implemented. The system pays all hospitals on an interim basis, common Medicare and Medicaid audits have been instituted, as well as denial of reimbursement for 8.5 percent nursing cost differential. In 1979, a limit was placed on the age of claims. Tape to tape billing has been proposed. During 1974 the nursing home reimbursement system established rate ceilings and in 1977 submission of single invoices by nursing home for all patients was instituted. Caps on administrative salaries have also been implemented. Measures which have been proposed, but not yet adopted, include a limit on capital costs, setting limits by cost centers and identical treatment of leased and owned facilities.

Physician services are reimbursed on the basis of usual, customary and reasonable charges. If allowed by the state legislature, these charges are updated using Medicare and Medicaid base year data approved

by the legislature. All practitioner fees are updated. Services rendered by a physician are reimbursed at rate for service when it was delivered, not billed and at a rate based on where service was delivered, not from where service is billed. Nurse practitioners and physician assistants are reimbursed indirectly by Medicaid as part of costs in rural health clinic audits.

In monitoring PSRO utilization review specific claims are noted, histories reviewed and a report written to the PSRO. The state allows a 5 percent overrun level. If this level is exceeded, meetings are held to resolve disputes. New Mexico's PSRO reviews claims for medical necessity prior to payment for certain services. The PSRO also reviews claims submitted by selected providers on a prepayment basis. The state agency monitors this activity.

Four utilization control measures have been implemented including the requirement that participating providers provide access to medical records, require identification of the ordering physician on laboratory, x-ray and prescription claims, lock in of high users to one physician and provider education. In 1979 two providers were suspended from the Medicaid program. A Medicaid Management Information System was implemented in 1975.

Total Medicaid expenditures increased from $56.705 million in 1978, to $69.855 million in 1980. In 1978 the state contributed 26.34 percent of the total, or $14.938 million, and in 1980 to 30.63 percent, or $21.399 million. Overall state outlays rose 43.25 percent from 1978 to 1980. The federal government's contribution in 1978 was 73.66 percent, or $41.767 million, and in 1980 69.37 percent, or $48.456 million. Medicaid enrollment also increased between 1978 and 1980 from 83,524 to 109,558. The average per day hospital room reimbursement rate rose from $170.42 in 1978 to $220.05 in 1980, an increase of 29.12 percent. Average non-specialist physician rates per office declined from $17.11 to $16.98 over the same period. Rates for SNF care rose 19.17 percent from $35.37 to $42.15, ICF care rose $20.32 to $22.14, and rates for home health visit grew from $18.27 to $21.78.

Categorical assistance was extended in 1978 to residents of public institutions such as correctional facilities and public child care facilities. In 1980 the guidelines for determining an individual's disability status were changed to consider whether that person is gainfully employed, that is engaged in subtantial physicial or mental activities normally done for renumeration. Earnings over $300 per month are considered gainful employment, less than $190 per month not so. Categorical eligibility also was extended to unemployed mothers and fathers in 1979. As of July 1, 1980, the Medical Assistance Only income exemption levels were increased so as to be consistent with federal requirements.

To control administrative errors and costs in eligiblity determination, the state began to monitor the performance of eligibility determination workers in 1975 and began training them in 1978. Welfare and Medicaid eligibility applications were also consolidated in 1980. Recipients who are no longer eligible for medical assistance are advised that their ID cards will become invalid after a particular time and that any attempt to use the card renders them liable to prosecution. To reduce client errors, monitoring of client income through linkages with other employment data files, and provider telephone inquiries to the state as to eligibility status were implemented in 1977. In addition, computerized data on client eligibility are now available for all New York City cases. The Welfare Management System (WMS) implementation has been initiated and eventually will provide data on client eligibility statewide; currently, the system functions in about 20% of the state.

During 1977, the state began retrieving Medicaid funds from health and casualty insurance, through federal financial participation in retroactive Medicaid eligibility determination and Medicare maximization. The state also has recovered funds from the Veteran's Administration and absent parents as of 1978 and 1980, respectively.

During 1979 podiatry and private duty nursing were added as rembursable services to Medicaid. Psychiatric social workers were added as covered services in 1980, as well as fullbodied CT scans and electromagnetic stimulation of a fracture nonunion.

Medicaid expenditures for mandatory benefits both increased and decreased during calender years 1978 and 1979. From calendar year 1978 to 1979 funding for inpatient hospital services rose from $848.399 million to $979,646 million, lab and x-ray from $11.813 million $15.064 million, SNF from $894.573 million to $1,00.404 million and family planning from $12.294 million to $12.455 million. Over the same two years funds for outpatient hospital services and rural health clinics decined from $223.065 million to $220.846 million, while physician service funds decined from $128.215 million to $118.789 million.

Optional funding for medical and other remedial care declined from $14.105 million to $9.086 million, and private duty nursing from $15.587 million to $11.425 million. Other optional services experienced an increase in funds, such as home health, which increased from $14.721 million to $22.299 million, clinic services from $74.554 million to $95.43 million, dental services from $47.731 million to $50.613 million, and drugs from $95.268 million to $101.980 million. ICF funds increased

from $222.867 million to $245.769 million, institution for mental diseases for those sixty-five and older from $220.211 million to $291.931 million dentures, prosthetics and eyeglasses from $11.525 million to $13.853, and physical, occupational and speech therapy from $4.715 million to $5.413.

The hospital reimbursement system adopted disallowance of weekend admission reimbursement for non-emergency services in 1976, peer group cost ceilings in 1972, excessive length of stay revenue penalties in 1977, and a revenue cap by target volume in 1980. Limiting reimbursement rates for services to the rate of the least expensive setting has always been a feature of the system. The system has always paid hospitals on an interim basis, pending audit findings, and conducted common Medicare and Medicaid audits. These audit findings are shared with fiscal intermediaries. Tape to tape billing was instituted in 1978, along with the MMIS system, and a limit placed on the age of claims in 1979. Features which have also been incorporated into the nursing home reimbursement system from the beginning are the establishment of rate ceilings, reimbursement according to peer grouping, limit on capital costs, submission of a single invoice by the nursing home, indexing of the reimbursement rate to economic trend factors, capping of administrative salaries, and imputing a useful lifetime to 40 years on nursing home facilites.

Measures which have been added include identical treatment of leased and owned facilities as of 1975, and elimination of efficiency incentives in 1976. Physicians are reimbursed on the basis of a fee schedule. As of 1967, reimbursement is at rate for service when it was delivered, not billed.

Changes in Medicaid rates include a limit on prescription drug reimbursement to a specific list developed by the Health Commission in 1978, and a revenue cap by target volume for hospital care in 1980 with a change in expenditures of approximately $7 million. A proposal was also made in 1980 to increase EPSDT fee for a comprehensive exam from $21.20 to $26.00, with an expected change in expenditures of $210,000. Physician assistants are reimbursed indirectly by the New York State Medicaid Program.

The state plan for monitoring PSRO utilization review activities involves quarterly site visits by the state health staff to randomly selected hospitals in each PSRO area for post payment medical record review and to determine the number of days which would have received state approval by state standards. Each year 25,000 of the cases are reviewed throughout the state, but no more than 20% of any one hospital. Each institution is sampled once during the year. To resolve conflicts between state monitoring and PSRO results, a physician arbitration panel, consisting of a PSRO representative, a state representative and a neutral member, reviews the findings when significant problems remain regarding the validity of findings. If a significant difference is noted and the PSRO does not institute corrective measures, the findings are reported to HCFA for futher action.

Prior review and authorization are required for nursing home care, home health services, hospital care, drugs-amphetamines, antibiotics supply of more than 14 days, durable medical equipment, rehabilitative services of private practitioner, private duty nursing, hearing aids, eye services and non-emergency transportation.

In 1978 Medicaid eligibility standards for the categorically eligible were changed when the income level was reduced by one-third for persons living in the household of another and not paying a proportionate share of household expenses. Changes in 1979 include the establishment of a reasonable class of minor children who require institutional care in excess of 180 days, and removal of financial responsibllity for children over age twenty-one who were handicapped prior to age eighteeen and were incapable of self support upon reaching the age of majority. For the medically needy, the AFDC-MA MN (Medcial needy) resource level was increased to SSI standards in 1978 and in 1979, the MN income level was increased from 127 percent to 133.33 percent of the AFDC payment standards. In 1979, spouse to spouse financial responsiblity, when one spouse is intitutionalized, was removed.

Measures to control administrative errors and costs in eligibility determination which have been adopted include training of eligibility determination workers as of 1974 and the monitoring of their performance since 1979. Retrieval of Medicaid ID cards also was instituted in 1979. Proposed measures are the consolidation of Welfare and Medicaid elgibility applications, and a major redesign of the entire eligibility system, consolidating functions and computerizing thoroughout the system to eliminate manual errors and reduce paperwork. To reduce client errors in eligibility, monitoring of client income through linkages with other employment data files and provider telephone inquiries to the state to determine eligibility status were implemented in 1978.

In 1974, the recovery of Medicaid funds through federal financial participation in retroactive Medicaid eligibility determination was initiated. Other programs to recover funds from health and casualty insurance were established in 1977, in addition to the creation of a Third Party Liability (TPL) recovery unit. Recovering funds from absent parents has also been proposed. Medicaid services were extended in 1978 and 1979 with the reinstatement of dental service in the Mediciad program at a cost of $10 million, as well as the beginning of coverage for therapeutic leave days in nursing homes.

Expenditures for mandatory Medicaid benefits both increased and decreased from 1978 to 1980. Funds for inpatient hospital services grew 16.2 percent from 1978 to 1979, from $82.8 million to $96.2 million, and increased 7.3 percent from 1979 to 1980 to $103.2 million. Outpatient hospital services increased slightly from 1978 to 1979, from $11.357 million to $11.404 million and in 1980 to $13.816 million. From 1978 to 1980 lab and x-ray services increased from $791,000 to $1.916 million, SNF services from $39.325 million to $54.349 million, and physician services from $28.660 million to $30.851 million. Expenditures for early and periodic screening and diagnostic testing rose from $1.163 million in 1978 to $1.418 million in 1979 and then declined to $1.379 million in 1980. Family planning funds declined from $2.071 million in 1978 to $1.635 million in 1980 and optometrist funds from $1.455 million to $1.2221 million.

Funds for optional benefits for medical or other remedial care,

which includes chiropractors, ambulances, podiatrists and hearing aids, also declined, from $9.436 million in 1978 to $8.612 million, in 1980. Home health care expenditures grew from $712,157 in 1978 to $1.208 million in 1980, and total clinic services from $4.526 million to $7.419 million, or 63.9 percent. Disaggregated, general clinic services increased from $1.444 million to $2.450 million and mental health clinic services from $3.082 million to $4.970 million over the same period. Dental care grew rapidly from $4.546 million in 1978 to $10.399 million in 1979, an increase of 129 percent and increased an additional 16.7 percent to $12.137 million in 1980. Drugs and optical supplies also increased from 1978 to 1980, drugs from $25.567 million to $31.0 million and optical supplies 58.0 percent from $887,746 to $1.402 million. Funding declined for institutions for mental diseases for those sixty-five and older, from $10.379 million in 1978 to $8.926 million in 1980, while funds for psyhiatric hospitalization for those under twenty-one rose from $1.707 million in 1978 to $3.913 million in 1980. Expenditures for ICF, ICR, and MRC care increased from 1978 to 1980, from $66.895 million to $112.678 million.

Hospitals in North Carolina are reimbursed on the basis of RCC, using Medicare guidelines. The hospital reimbursement system adopted common Medicare and Medicaid audits in 1974 and limited the age of claims in 1980. Tape to tape billing has been proposed as an added measure. The nursing home reimbursement system adopted several measures beginning in 1970 with the establishment of rate ceilings, limiting capital costs, caps on administrative salaries, imputing a useful lifetime of forty years to nursing homes facilities and identical treatment of leased and owned facilities. Other measures adopted include indexing reimbursement rates to economic trend factors in 1978, beginning submission of single invoices by nursing home for all patients in 1979, and setting limits by cost centers in 1980. Pass-throughs have also been prohibited.

Physician services are reimbursed on the basis of usual, customary and reasonable charges which are updated annually following Medicaid guidelines. All fees are updated annually except pharmacists, which require legislative action. Per capita payment for each recipient accepted by physicians.

The North Carolina PSRO monitoring plan, approved in May of 1979, utilizes a retrospective claims review based on a stratified random sample of hospital claims. The sample size is no more than 205 claims per PSRO per quarter, and yields a sample of approximately 6 percent. The sample claims are first screened against the LOS/DX file; claims which "except" are manually reviewed and referred to a physician if questions still remain. Medical necessity, appropriateness, and LOS are considered. Questioned claims are referred to the responsible PSRO with a rationale for the physician consultant's review decision. The PSRO may submit additional information in support of their determination. This is reviewed by the state's physician consultant and the claim is resolved as "acceptable" or "unacceptable" for monitoring purposes. Monitoring began in the second quarter of Fiscal year 1980 (October 1979). For that quarter the PSRO had four days approved which the state would not have approved; for the third quarter the PSRO had 0 days the State would not have approved.

Prior approval is required for the following services: cosmetic surgery, surgical transplants (excluding bone, tendon, corneal and renal); outpatient psychiatric services after two visits; ICF and SNF placement; out-of-state services; bypass surgery for obesity; eye refractions; eyeglasses; reduction mammoplasty; sex transformation surgery; craniofacial surgery; excision of keloids; and, nuclear powered pacemakers. Home health services required prior approval until February, 1980, at which time the requirement was removed. A retrospective review is now being done.

Beginning in 1978 several utilization control measures were adopted starting with the requirement that participating providers provide access to medical records and in 1975 a limitation on the length of stay for stays without PSRO approval, the limitation being based on medical necessity. Provider and patient education were implemented in 1978, a change in coverage or reimbursement rate for administrative days from 10 to 3 and lock in of high users to one physician in 1980.

North Carolina applied many sanctions against providers in both 1979 and 1980. In 1979, twenty-three providers were suspended from the Medicaid program and five in 1980; four were removed in 1979, three fines were applied in 1979 and two in 1980; five providers were assigned jail sentences in 1979 and two in 1980 and funds were recouped from fifty providers in 1979 and twenty-nine in 1980. In regards to clients, funds were recovered from 270 in 1979 and from 175 in 1980.

Although no Medicaid recipients are as yet enrolled in prepaid group practices the 1979 state legislature established and funded a legislative commission to study the feasibility of promoting HMO development in North Carolina. The 1980 legislature authorized Medicaid coverage for prepaid group practices.

To enhance program administration Medicaid contracted out drug claims processing in 1973, utilization review in 1974 and all claims processing in 1975. In 1977 a Medicaid Management Information System was implemented and in 1978 a separate division for administration of Title XIX was established; it had previously been the responsiblity of the Public Welfare Agency.

Total Medicaid expenditures increased from $288.298 million in 1978 to $389.788 million in 1980. In 1978, the state contributed 28.38 percent of the total ($81.829 million), the federal government 66.98% ($193.101 million), and the local sector 4.64% ($13.368 million). Contributions in 1979 were 26.95% from the state ($96.315 million), 67.29% from the federal government ($240.524 million), and the local sector 5.76% ($20.606 million). For 1980, the state contributed 26.7% ($103.991 million), the federal government 67.2% ($261.846 million), and local government 6.0% ($23.351 million). Total Medicaid enrollment declined slightly from 455,774 in 1978 to 453,000 in 1980. However, the number of categorical eligibles declined from 398,241 to 385,050, while the number of medically needy rose from 47,533 to 67,950 over the same period. State expenditures of non-Medicaid general medical care also increased, from $144.9 million in 1978 to $174.5 million in 1980. Provider reimbursement average annual rates also rose from 1978 to 1980 including: per day hospital room rate from $84.35 to $112.78; non-

specialist physician office visit from $7 to $10.70; per day SNF rates from $21.66 to $28.90; ICF per day rates from $18.79 to $21.59; and average home health care visit rate from $20.54 to $24.04.

During 1978 North Dakota increased income standards for the medically needy and increased cash exemptions for medically needy one and two person per households.

Training of eligibility determination workers and monitoring for their performance has been implemented so as to control administrative errors and costs in eligibility determination. Welfare and Medicaid elibibility applications have also been consolidated so as to minimize errors. To reduce client errors monthly client status reports and provider telephone inquiries to the state as to eligibility status also have been implemented.

North Dakota has implemented a program to recover Medicaid funds from absent parents, the Veteran's Administration, health and casualty insurance and CHAMPUS.

Clinic services were added to Medicaid covered services in FY 1981 at a cost of $280,000. ICF care for the mentally retarded has been proposed for the 1981 legislative session subject to legislative approval, with an estimated cost of $12 million for implementation.

Mandatory Medicaid expenditures for inpatient hospital services increased from $7.111 million in 1978 to $9.817 million in 1980, an increase of 38%. Outpatient hospital services and rural health clinc funds rose during this period from $429,411 in 1978 to $722,975, while lab and x-ray spending declined from $553,802 in 1978 to $92,551 in 1980. SNF outlays grew from $11.770 million in 1978 to $15.959 million in 1980, an increase of 35.6%. Physician services spending grew from $3.093 million to $3.709 million, as did EPSDT outlays from $113,713 to $141,223. Family planning funds declined from $115,387 in 1978 to $46,216 in 1980. Optional expenditures for home health care increased from $39,699 in 1978 to $62,730, while private duty nursing funds rose from $23,457 to $544,432. Dental outlays grew from $1.267 million to $1.692 million, an increase of 33.54% from 1978 to 1980. From 1978 to 1980 drug funds rose 20.46% from $2.287 million to $2.775 million, funding for institutions for mental disease for those sixtyfive and older by 51.31% from $1.684 million to $2.548 million, and ICF funds by 51.68% from $6.382 million to $9.680 million.

The state's hospital reimbursement system has proposed disallowance of weekend admission reimbursement for non-emergency services. As of 1972 common Medicare and Medicaid audits have been conducted. All hospitals are paid on an interim basis and a limit has been placed on the age of claims. Tape to tape billing was instituted in 1978. The nursing home reimbursement system has since 1974 treated leased and owned facilities in the identical manner, set limits by cost centers and indexed reimbursement rates to economic trend factors. In 1976 caps were placed on administrative salaries and submission of a single invoice by nursing home for all patients implemented in 1978.

Physician services are reimbursed on the basis of usual, customary and reasonable charge. The fees are updated annually using the Medicare index and Medicare adjustments. The state also uses the same method for non-Medicare procedures. Prior to the 1978, reimbursement has been and still is at the rate for where the service was delivered, not from where service is billed.

The State plan for monitoring PSRO utilization review activities involves selection of a 10% sample of all the claims received. Professional review is applied against PAS regional length of stay data. Ancillary services are currently being reviewed through joint efforts between the PSRO/State Agency by an exchange of data utilizing PSRO data and the state MMIS. Conflicts are resolved through discussion on a staff to staff basis.

Prior authorization is required on dental crown and bridge work based on professional review. All SNF and ICF patients are reviewed prior to admission. Second opinions are available if a recipient so chooses. Medical consultants review all proposed intestinal by-pass surgery and out of state referrals for highly specialized Medical procedures.

Prior to 1978 disallowance of claims and requiring participating providers to provide access to medical records were instituted to control utilization. In 1978 several other utilization control measures were implemented including required identification of the ordering physician on laboratory, x-ray and prescription claims, patient and provider education, and lock in of high users to one physician and to one pharmacy. Monitoring of hospital discharge planning units will be implemented in 1981. North Dakota does not pay for administrative d. During 1979 two providers were suspended from the Medicaid program and two were fined. One provider was suspended in 1980.

No Medicaid recipients are enrolled in prepaid group practices. There is one rural HMO in the state and the state has determined that there are not sufficient Medicaid clients to warrant program participation given the red tape involved. A MMIS was implemented in 1978.

Total Medicaid expenditures grew from $35.951 million in 1978 to $47.988 million in 1980. State funding grew from $18.849 million to $28.145 million, while federal outlays rose from $14.725 million to $16.980 million over the same period. Local spending grew from $2.376 million in 1978 to $2.773 million in 1980. Medicaid enrollment rose from 25,930 in 1978 to 26,650 in 1980. Provider reimbursement rates also increased over the same period with average per day hopital room reimbursement rate, including services paid by SSB, increasing from $142.39 in 1978 to $165.42 in 1980, a 26% rise. From 1978 to 1980 average SNF rate rose 29.98% from $18.58 to $24.15 and ICF rate by 33.96% from $13.34 to $17.87.

Effective January 1, 1980, Ohio's Medicaid eligibility criteria for the categorically eligible were brought into line with federal requirements. Ohio's former criteria were less restrictive than federal requirements allowed; thus federal financial participation was not available. The state legislature mandated grandfathering of recipients eligible under former criteria, creating a group of persons provided for by state funds only. The overall impact of the recipient population is unknown. No changes were made in Medicaid covered services.

To control administrative errors and costs in eligibility determinations, the state since 1967 has used combined welfare and Medicaid eligibility applications, training for eligibility determination workers and monitoring of their performance. Medicaid ID cards are good only for one month in Ohio. Error prone profiling has been proposed. To reduce client errors, provider verification of client identification and personal pick-up of checks were also instituted in 1967, and photo IDs in 1975. Monitoring of client income through linkages with other employment data files was started in 1978. Monthly client status reports have been proposed.

Medicaid fund recovery was started in September 1968 through federal financial participation in retroactive Medicaid eligibility determination. In 1975 a program was started to retrieve funds from Medicare and in 1976 from Champus, health and casualty insurance. Absent parents have also been proposed as a source for the retrieval of funds.

Mandatory Medicaid expenditures for inpatient hospital services declined 6.7% from $187.886 million in 1978 to $176.091 million in 1979. However, funds increased 17.73% in 1980 to $207.317 million. Funding for outpatient hospital expenditures displayed a similar pattern, declining 4.1% from $41.902 million in 1978 to $40.257 million in 1979, but increased 12.4% to $45.253 million in 1980. Lab and x-ray expenditures declined from $1.681 million in 1978 to $1.243 million in 1980, while SNF funds increased from $136.475 million $176.920 million. Many dual facilities became ICF rather than Medicare certified.

Physician services declined steadily, from $60.450 million in 1978 to $50.265 million in 1980, and early and periodic screening and diagnositc testing expenditures from $1.728 million to $1.583 million in 1980. Family planning funds increased from $1.020 million in 1978 to $4.226 million in 1980. Finally, optometrist funds declined from the 1978 level figure of $6.291 million to $5.773 million in 1980.

Some optional expenditure programs also declined in funds, although funds for medical and other remedial care increased each year for a total increase of 21.64% from $16.457 million in 1978 to $20.018 million in 1980. Home health and clinic service funds, however, both declined in 1979 and, although there were some increases in 1980, the overall increases were less than the 1978 level for a total decline of 6.67% and 11.13%, respectively. In excess of $1 million was allocated for home

health in 1978 and $989,000 in 1980; $3.883 million in 1978 and $3.494 million in 1980 was appropriated for clinic services. Expenditures for dental services rose from $11.956 million in 1978 to $13.049 million in 1980, while drug funds increased from $38.744 million to $44.709 million. For regular ICF care and mental retardation, ICF care funds increased significantly each year from $29.418 million in 1978 to $93.120 million in 1980 for regular ICF care, and from $1.540 million in 1978 to $9.870 million in 1980 for mental retardation ICF care.

Hospitals in Ohio are reimbursed on the basis of Medicare reasonable costs. The reimbursement system also pays hospitals on an interim basis as of 1967 and has implemented tape to tape billing, reimbursement on a hospital department basis, denial of reimbursement for 8.5% nursing cost differential, and placed a limit on the age of claims. As of 1967 the nursing home reimbursement system established rate ceilings, placed a limit on capital costs in 1976, and began setting limits by cost centers and placed caps on administrative salaries in 1977. In 1980 the system eliminated efficiency incentives, tied reimbursement rates to grades of patient disability, began indexing reimbursement rate to economic trend factors, and imputed a useful lifetime of 40 years on nursing home facilities.

Physician charges in Ohio are reimbursed both usual, customary and reasonable charges and on a fee schedule basis. In reimbursing physicians a limit has been placed on the number of billable procedures since 1972, and reimbursement is at the rate for service when it was delivered, not billed. The rates have not been increased since 1972.

In 1979 the Medicaid dispensing fee was increased at a cost of $7 million. During 1980 changes were made in the nursing home program also at a cost of $20 million and comprehensive clinics reimbursed on a prospective basis.

Physician assistants in rural health clinics only are reimbursed indirectly by the Medicaid program, and the state plan for monitoring PSRO utilization review activities monitors length of stays for the 30 most frequently billed diagnoses.

Among the services for which Ohio requires prior authorization are some types of prostheses, durable medical equipment, medical supplies and, beyond established limits, physician visits, hospital days, physical therapy, outpatient clinics and private duty nurses.

Utlilization controls which were adopted in 1967 are provider education and the requirement that participating providers give access to medical records; in 1972 the state required identification of the ordering physician on presciptions, x-rays and laboratory claims. In 1973 surveillance and utilization reviews were implemented along with a Medicaid Management Information System (exception reporting and monitoring.) As of 1975 stays without PSRO approval are not paid for, and as of 1980 coverage or reimbursement rates for administrative days in nursing homes were changed. Disallowance of claims has also been implemented.

Sanctions were applied against many Ohio providers in 1979 and 1980. During 1979 one provider was suspended from the Medicaid program and eleven in 1980, while thirty-two were removed in 1979 and twenty-

three in 1980. Fines were levied against eleven in 1979 and fifteen in 1980; ten were given jail terms in 1979 and nine in 1980.

While no Medicaid recipient was enrolled in a prepaid group practice in 1978, 2000 were enrolled in 1979 and 2200 in 1980. Ohio offers no cash incentives to join a HMO and the medical assistance card is replaced by HMO ID card card so as to avoid the stigma of a welfare card. To those recipients enrolled in an HMO, routine preventive services not available under Mediciad are available under an HMO, while HMO enrollees are not subject to Medicaid visit limitations. In addition, those recipients enrolled in HMOs have better access to dental services, especially routine dental care, as the rate of provider participation in the Medicaid dental program is low. In return, providers gain from the absence of a limit on the number of visits allowed; they do not have to process their own claims and they are free from constant programmatic changes.

During 1972 a Medicaid Management Information System was implemented, and in 1978 the state began contracting out for key punch and in 1979 some audits. Bulk purchases of eyeglasses has been proposed.

Total Mediciad expenditures declined in Ohio from $696.988 million in 1978 to $636.983 million in 1979, a decline of 9.42%. However, expenditures increased in 1980 to $761.933 for a total increase of 9.32% from 1978 to 1980. The state's outlay rose from $308.987 in 1978 to $321.325 million in 1980 an increase of 3.99%. SNF and ICF rates both increased by 24.32% and 18.32%, respectively, from $17.72 in 1978 to $22.03 in 1980 and $14.57 in 1978 to $17.24 in 1980. Average rates for home health visits remained essentially the same at $19.19 in 1978 and 1980.

Oklahoma's Medicaid program has implemented a program to recover Medicaid funds from health and casualty insurance and through federal participation in retroactive Medicaid eligibility determination.

Medicaid covered services were extended to rural health clinics in 1979 and the maximum payment to be paid on behalf of a recipient to physicians and hospitals with respect to any one disease raised to $40,000. The dispensing fee for prescribed medication was raised to a maximum of $3.00 per prescription in 1980 at a cost of $1 million. In 1980, the drug program was expanded to include 8 new therapeutic categories, the limit on cancer prescription released, and payment for ambulance services to match Title XVII screens adopted.

Medicaid expenditures in 1978-1979 for mandatory benefits increased in virtually all categories except family planning, which declined from $447,284 to $120,244 or by 272 percent. Over the same period funds for inpatient hospital services rose 20.5 percent from $46.815 million to $56.401 million, outpatient hospital services and rural health clinics 3 percent from $205,280 to $211,523, lab and x-ray 35.1 percent from $491,670 to $664,153, and, SNF care 157% from $21,712 to $55,684. The second largest mandatory expenditure, physician services, increased 10.9 percent from $16.834 million to $18.673 million and early and periodic screening and diagnostic testing increased 32.2 percent from $153,343 to $202,820.

Funds for optional benefits, such as medical or other remedial care, also increased from $3.427 million to $3.721 million and for home health care from $10.150 million to $13.841 million or 36.37 percent from 1978 to 1979. Other optional benefits which increased from 1978 to 1979 include dental care, $2.3 million to $2.8 million; drugs, from $6.5 million to $7.6 million; and institutional care for those 65 and older with mental diseases from $2.7 million to $3.2 million. Psychiatric hospitalization for those under 21 decreased from $387,282 to $333,814. The largest optional expenditure was for ICF care which increased from $108.289 million to $143.483 million.

The hospital reimbursement system reimburses hospitals on an interim basis and has common Medicare and Medicaid audits, as well as reimbursement on a hospital department basis. In 1966 a limit was placed on the age of claims and tape to tape billing was proposed in 1980. The state's nursing home reimbursement system has also adopted several measures such as the establishment of rate ceilings, reimbursement according to peer grouping, submission of a single invoice by a nursing home for all patients, limiting pass-throughs, setting limits by cost centers, indexing reimbursement rates to economic trend factors, and identical treatment of leased or owned facilities.

Physician services are reimbursed on usual, customary and reasonable charges. Title XIX is paid based on Title XVII profiles which are updated annually. In 1966 the state also placed a limit on the number of billable procedures and instituted reimbursement at a rate based on where service was delivered, not from where service is billed.

All nursing and personal care recipients must review prior authorization. The recipient's doctor must submit a medical exam and the case worker a social summary, both of which are reviewed in the state office by a team consisting of a physician and a medical social worker. Additional information is obtained as needed. Other utilization controls which have been adopted include provider education and disallowance of claims. In 1966, participating providers were required to provide access to medical records and the identification of the ordering physician was required on lab and x-ray claims and, beginning in 1975, on prescription claims. Limitations on length of stays without PSRO approval were initiated in 1977. A Medicaid Management Information System was implemented in 1972.

Medicaid expenditures increased from $223.165 million in 1978 to $257.524 in 1979, an increase of 15.4 percent. The state contributed $92.573 million or 41.48 percent and the federal government $130.591 million or 58.52 percent in 1978. Contributions in 1979 are $121.121 million for the state or 47.03 percent and $136.403 million or 52.97 percent for the federal government. Overall, the state's contribution increased 30.84 percent from 1978 to 1979 and the federal government's 4.45 percent.

To control administrative errors in ineligibility determinations, the state instituted training of Medicaid eligibility workers and monitoring of their performance, as well as consolidation of welfare and medicaid eligibility applications. Provider telephone inquiries to the state to determine eligibility status was implemented before 1967 to reduce client errors. Other measures introduced in 1971 to meet this goal are monthly client status reports and personal pick-up of checks. Client income also is monitored through linkages with other employment data files.

Before 1965, a program was implemented to recover Medicaid funds from casualty insurance and in 1974 from health insurance. As of 1972, recoupment of funds through federal financial participation in retroactive Medicaid eligibility determination has been utilized.

Changes in Medicaid covered expenses in 1978 disallow reimbursement for certain medical procedures of unproven efficacy such as a gastrointestinal by-pass for obesity. Also implemented is a requirement that prior authorization be obtained for certain medical procedures to permit an agency consultant to assess the medical necessity and the reasonableness of the proposed services. A 1979 change reimburses rural and Indian health clinic services on a flat rate. Two changes were made in 1980; one reimburses certified nurse practitioner services independent of physician supervision, and the other restricts in-hospital treatment of alcoholism to a period of acute detoxification with prior authorization for all hospital inpatient days beyond the first three.

Mandatory Medicaid benefits for inpatient hospital services totaled $31.347 million in 1978, $32.796 million in 1979 and $33.351 million in 1980. The second largest mandatory expenditure is for physician services, which declined from $18.433 million in 1978 to $17.249 million in 1980. Lab and x-ray expenditures dropped from 1978 to 1980 by 13.5 percent, from $2.961 million to $2.608 million, while SNF care grew by 15.2 percent from 1978 to 1980, from $4.466 million in 1978 to $5.145 million in 1980. Funds for several other programs such as early and periodic screening and diagnostic testing also displayed a similar pattern, growing from $749,002 in 1978 to $792,495 in 1980. Family planning expenditures decreased from $1.301 million in 1978 to $975,377 in 1980 while funds for optometric services including opthalmologists and dispensing physicians, declined from $674,209 in 1978 to $642,800 in 1980.

Optional benefits also experienced increases and decreases. Funds for home health care increased from $170,188 to $203,281, from 1978 to 1980, while dental benefits declined from $4.202 million in 1978 to $4.135 million in 1979 but then increased again to $4.948 million in 1980. Drug funds increased steadily from 1978 to 1980 growing by 13.5 percent from $7.360 to $8.355 million. ICF also grew, from $64.840 million in 1978 to $87.894 million in 1980.

The Oregon hospital reimbursement system began to limit the age of claims in 1980. The nursing home system has adopted several measures such as: the establishing rate ceiling; reimbursing according to peer grouping; limiting capital costs; submitting single invoices by nursing homes for all patients; setting limits by costs centers; indexing the reimbursement rate to economic trend factors; putting caps on administrative salaries; imputing a useful life time of 40 years on nursing home facilities; and treating identically leased and owned facilities.

Physician services are reimbursed according to the fee schedule. In reimbursing physicians the number of billable procedures has been limited, and reimbursement is at the rate for service when it was delivered, not billed, where service was delivered, not from where service is billed, and for office or ambulatory surgery at a rate less than that for hospital charges.

During 1978, Medicaid reimbursement of outpatient charges was limited to 75 percent of reasonable cost and inpatient reimbursed at 100 percent of costs. Two changes were implemented in 1979: rural and Indian health clinics are reimbursed at a flat rate determined by GAO and Medicare, and reimbursement for specified durable medical equipment and for clinical lab procedures is on the basis of Medicare determination of lowest available charge. Medicare also builds provider profiles for these services. The Medicaid program reimburses nurse practitioners and physician assistants directly for services performed.

Several prior review/prior authorization requirements were adopted in 1968 including: non-emergency dental care, opthalmic materials, miscellaneous medical care, non-emergency medical transportation, and speech therapy. Measures requiring prior review/authorization in 1979 are: personal care services, home health, naturopath, chiropractor, non-emergency podiatrists, physical therapy, private duty nurse, durable medical equipment, supplies and equipment, and oxygen. In 1980, nursing home placements and pre-admission screening were added to the list. Psychotherapy provided by a psychologist or social worker, non-emergency psychotherapy by a physician, and certain pharmeceuticals (i.e., amphetamines) also require prior authorization.

Utilization controls which have been adopted by the state include disallowance of claims, a limitation on length of stay without PSRO approval, a requirement that participating providers provide access to medical records and that the identification of the ordering physician accompany laboratory, x-ray and prescription claims. Patient education and lock in of high users to one physician are proposed, as well as an expansion of provider education. Sanctions imposed by the state include sending one provider to a jail term in 1980.

The number of Medicaid recipients enrolled in prepaid group practices in 1978 were 8,938, in 1979 10,083 and in 1980 7,291. AFS offers to contract with any HMO or PHP as long as it is to the financial advantage of the state. In certain localities, AFS offers enrollment as an option in the ADC, and semi-annually sends a letter to all ADC recipients offering the enrollment option. Measures to enhance program administration include bulk purchasing of hearing aids as of 1973 and in 1981, a proposed Medicaid Management Information System, and integrated eligibility in 1982.

Total Medicaid expenditures increased from $150.004 million to $175.376 million. In both 1978 and 1979 the state contributed 42.71 percent of the total, and 44.34 percent in 1980. The federal government contributed 57.29 percent in both years, and declined to 55.66 percent in 1980. Overall, the federal government's outlay of funds grew 13.59 percent from 1978 to 1980 while the state's outlay increased by 21.36 percent. Total Medicaid enrollment declined over the same period from 157,610 to 138,811. Non-Medicaid state general assistance expenditures for medical care grew from $1.085 million in 1978 to $15.402 million in 1980. Average per day hospital room reimbursement rate also increased, from $219.35 in 1978 to $257.48 in 1980. The average non-specialist physician rate per office visit increased 15.39 percent from 1978 to 1980, from $17.41 to $20.09. From 1978 to 1980, the average per day SNF rate rose from $31.51 to $46.75. The ICF rate from $22.55 to $26.80, and the home health visit rate $30.00 to $35.00.

For the medically needy, Rhode Island established new income limits effective July 1, 1979. The new limit is $4,400 for 1 person, $4,900 for 2 persons, etc. The medically needy income limits in Rhode Island are established by state law at 133.33% of the AFDC standard.

The state adopted several measures to control administrative errors and costs in eligibility determinations and reduce client errors. This effort began in 1966 with the consolidation of welfare and Medicaid eligibility applications, training of eligibility determination workers, provider verification of client identification and provider telephone inquiries to the state as to eligibility status. In 1974 monitoring of the eligibility determination worker performance was started. A photo ID requirement was implemented in 1975 and monitoring of client income through linkages with other employment data files was instituted in 1977.

Rhode Island has implemented programs to recover Medicaid funds from the Veteran's Administration, health and casualty insurance, through federal financial participation in retroactive eligibility determination and all other applicable third party resources. Absent parents became a source for retrieval of funds in 1979.

Medicaid expenditures increased and decreased for both mandatory and optional programs. Between 1978 and 1980 mandatory benefits, such as inpatient hospital services, increased from $44.875 to $57.335 million. Outpatient hospital services also increased 12.98% from 1978 to 1979 and 13.54% from 1979 to 1980. Outpatient hospital services increased in this period from $4.629 million in 1978 to $6.0 million in 1980, and lab and x-ray funds from $319,210 to $342,879. SNFs expenditures declined substantially from $8.883 million in 1978 to $2.222 million in 1980. Physcian services and optometrist services both increased from 1978 to 1980 by 6.65% and 20.99%, respectively, from $5.065 million to $5.402 million and from $709,908 to $858,884. Early and Periodic Screening and Diagnostic Testing outlays almost doubled from $132,112 in 1978 to $257,434 in 1980, while family planning spending declined from $475,771 in 1978 $362,378 in 1980.

Optional benefit programs exhibited a similar pattern as the manadatory programs. Funds for medical and other remedial care increased slightly $94,973 in 1978 $100,943 in 1980. Funds for home health care increased steadily from $214,830 in 1978 to $256,787 in 1979 to $260,675 in 1980, an increase of 21.34%, while funds for dental care and dentures increased from $2.720 million in 1978 to $2.889 million in 1980. From 1978 to 1980 drug outlays grew by 20.2% from $6.637 million to $7.977 million and 81.5% for prosthetics and medical equipment, from $369,238 to $670,293 over the same period. The largest optional expenditures were for ICF services which increased 106% from 1978 to 1980, increasing from $24.067 million to $39.869 million to $49.490 million in each of the three years. Institutions for mental diseases for those sixty-five and older also underwent a decline in funding from $3.816 million in 1978 to $1.142 million in 1980, a decline of 234%.

Hospitals in Rhode Island are reimbursed on the basis of negotiated prospective payment rates between the state, hospitals and hospital service corporations. The negotiating parties, Blue Cross, the State Budget Office and the Hospital Association of R.I., determine the maximum percentage increase which will be allowed for total hospital expenditures in the following year. In determining the maximum increase, hospitals are required to provide cost data on their current and future budgets and the incremental changes between the two years are reviewed in the aggregate and on a cost center basis. Although hospitals are grouped together, limited use is made of inter-hospital comparisons. The negotiating parties, while reviewing the incremental change, must consider such factors as inflation, changes in volume and the provision of new and expanded services. Once total operating expenditures have been determined, a schedule of changes based on the total projected expenses is established by each hospital. Blue Cross and the State Budget office then analyzes the schedule of charges to access the accuracy of revenue calculations and, if the schedule is accurate, it is then used Blue Cross and Medicaid after being adjusted for cost and benefit differences, to establish separate rates. This program has been in operation since 1975.

The hospital reimbursement system also placed a limit on the age of claims in 1966, implemented denial of reimbursement for 8.5% nursing cost differential and common Medicare and Medicaid audits in 1979. The nursing home reimbursement system established rate ceilings in 1968 and placed caps on administrative salaries. In 1978 a limit was placed on capital costs; limits were set by cost centers and the reimbursement rate indexed to economic trend factors. The system also forbids pass throughs.

Physicians in Rhode Island are reimbursed on a fee schedule basis. As of 1966 a limit has been placed on the number of billable procedures, and reimburement is at the rate corresponding to when and where the service was delivered.

In the state plan for monitoring PSRO utilization review activities, the overall number of claims in the post payment monitoring quarterly sample should equal 20% of all discharges, but not less than 50 nor more than 150. For example, 500 discharges would require a sample size of 100 in order to equal 20% and therefore the skip interval would be 5. Key measures used in the sampling are: inpatient stays with excessive ancillary services; inpatient stays exceeding the average length of stay norms for certain cases (e.g., cataracts, appendicitis, hysterectomy, tonsillectomy and adenoidectomy, dental services, psychiatric diagnosis); and assignment of administrative days. To resolve conflicts between state monitoring and PSRO results, the process provides for an exchange of correspondence relative to the post payment monitoring results and, provides for a meeting between the two parties if the dispute has not been resolved via the exchange of correspondence. In fiscal year 1979 the average length of stay approved by the PSRO is 6.3 days, as opposed to the 6.2 days which the state agency would have approved. The PSROs also approved 4145 short stay hospital days in contrast to 4110 the state would have approved.

Since the inception of the program on July 1, 1966 the following prior authorization requirements have been incorporated into the program:

inpatient hospital surgical procedures of a cosmetic nature which is necessary for functional purposes; physical, occupational and speech therapy; clinical laboratory tests not listed on the clinical lab fee schedule, and special diagnotic/therapeutic x-rays not included on the x-ray fee schedule; admission to a SNF; office visits to a psychiatrist beyond the inital evaluation visit; podiatry services (x-rays balance inlays and molded shoes); optometry services (perceptual visual training and visual examination when the interval between the last exam is less than one year): home health services visits in excess of 8 per month; medical supplies; equipment and appliances; dental services including oral surgical procedures and dentures except for emergency and palliative treatment; examination and charting; prophylaxis and x-rays; drugs such as central nervous stimulants, appetite suppressants, injectibles excluding insulin and adrenalin and certain expensive drugs; all prosthetic devices; eyeglass frames costing more than $8.00; contract lenses and for lenses other than corrected curve single vision lenses; kryptok bifocals and cataract corrective lenses; ICF care; and services for persons sixty-five years or older in institutions for mental diseases.

In 1966 three utlization control measures were implemented--disallowance of claims and lock in of high users to one physician, and the requirement that participating providers give access to medical records. As of 1978 the identification of the ordering physician on laboratory, x-ray and prescription claims was required. During 1979 one provider was suspended from the Medicaid program and one suspended in 1980, one was removed in 1979 and one was fined in 1980.

The total number of Medicaid recipients enrolled in prepaid group practices were 118 in 1978, 128 in 1979 and 134 in 1980. Manual materials are provided and educational sessions are conducted by HMO representatives for social service staff which identify this alternative Health Care Delivery System.

Total Medicaid expenditures reached $115.780 million in 1978, $135,453 million in 1979 and $155,717 million in 1980, and increase of 16.99% percent from 1978 to 1979 and 14.96% percent from 1979 to 1980. States outlays grew 32% from $49.785 million in 1978 to $65.697 in 1980, while the federal expenditures increased from $65.994 million to $90,020 million, an increase of 36.4%. Proportionately, the state's share is 43% of the total annual out-lay and the federal share is 57%.

Total Medicaid enrollment declined from 87,187 in 1978 to 83,013 in 1980. From 1978 to 1980 the number of categorical eligibles enrolled declined from 71,879 to 68,134 and medically needy from 15,308 to 14,879. Provider reimbursement rates rose 11.3% from $115.0 in 1978 to $128.0 in 1979 and by 6.3% in 1980 to $136.0. Non-specialist physician rate per office visit remained at $9.00 during 1978 to 1979, but increased to $12.00 in 1980; the average home health visit rate remained at $12.00 during 1978 and 1979 and rose to $16.00 in 1980. Average daily rates for SNF and ICF increased by 39.14% and 34.4% respectively, from 1978 to 1980, SNF increasing from $27.31 to $38.0 and ICF from $22.91 to $30.79.

Medicaid categorical eligiblity standards were changed by increases in the Medicaid cap for individuals from $335 to $430 in 1978, $430 to $624 in 1979 and $624 to $714 in 1980. No significant change has occured in Medicaid covered services or in reimbursement rates, rate ceilings and/or copayment.

To control administrative errors and costs in eligibility determination, South Carolina consolidated welfare and Medicaid eligiblity applications and trains eligiblity determination workers as needed, and as of 1977 has monitored the workers' performance. Error prone profiling was instituted in 1978 for AFDC and is being proposed for Medicaid. Medicaid cards are issued on a monthly basis. To reduce client errors providers have always been required to verify client identification. Monitoring of client income through integration with other employment data files and provider telephone inquiries to the state as to eligibility status were implemented in 1979 and 1980, respectively.

Programs to retrieve Medicaid funds from health insurance were implemented in 1968 and from casualty insurance and Medicare in 1969. Fund retrieved from absent parents has been proposed for 1980.

Expenditures for mandatory Medicaid programs, such as inpatient hospital services, increased from $35.676 million in 1978 to $48.752 million in 1980, an increase of 36.65%. For outpatient hospital services and rural health clinics outlays grew by 28.13% from $4.835 million in 1978 to $6.195 million in 1980. Lab and x-ray funds also increased 19.2% from $1.656 million in 1978 to $1.974 million in 1980, as did physician service funds from $12.416 million in 1978 to $14.992 million in 1980. SNF funding declined from $36.965 million in 1978 to $21.281 million in 1980, while EPSDT funds increased from $632,977 in 1978 to $777,681 in 1980. Funding for family planning also declined from $1.655 million in 1978 to $1.563 million in 1980, while opometrist funds rose from $871,283 in 1978 to $966,902 in 1980.

Optional expenditures for medical and other remedial care was $19.821 million in 1978, and $20.532 million in 1980. Funding for home health increased 81.1% from $662,000 in 1978 to $1.199 million in 1980, and dental service funds rose 6.1% from $3.572 million in 1978 to $3.790 million in 1980. From 1978 to 1980 drug funding grew 31.88% from $11.542 million to $15.222 million; funds for dentures, prosthetics and eyeglasses increased by 80.65% from $586,764 to $1.060, million, and, for ICF by 266% from $17.651 million to $64.529 million.

The South Carolina hospital reimbursement system pays hospitals on a PIP basis if they so desire. Disallowance of weekend admission reimbursement for nonemergency services has also been implemented and hospitals are reimbursed on the basis of Medicare reasonable costs. Since 1974 Medicaid and Medicare common audits have been implemented. A limit has been place on the age of claims, denial of reimbursement for 8.5% nursing cost differential instituted and tape to tape billing proposed. During 1978 the nursing home system established rate ceilings and reimbursement according to peer grouping, placed a limit on capital costs, allowed submission of a single invoice for all patient, began

setting limits by cost centers, indexed the reimbursement rate to economic trend factors, and placed caps on administrative salaries.

Physician fees are updated in July of each year based on the proceeding calender year's usual, customary and reasonable charges. Reimbursement of physcians is at rate for service when it was delivered, not billed and at rate where service was delivered, not from where service is billed. A limit has been placed on the number of billable procedures. Physician assistants are reimbursed indirectly by the Medicaid program at the rate of $7.00 per office visit. The rate has remained the same in 1979 and 1980.

South Carolina will monitor PSROs through onsite review of a sample of cases, the review focusing on medical necessity and professional care standards. Trend analyses of physician participation patterns, rehabilitation of Medicaid patients and the impact on state expenditures will also be conducted. MMIS support will contribute to the review. If conflict between the state agency and the PSRO cannot be resolved, the regional HCFA office will be notified and procedures in the Memorandum of Understanting implemented.

Prior authorization is required under the EPSDT program for the provision of eyeglasses and repairs and a limited number of dental procedures and hearing aids. Several utilization controls will be implemented including the requirement that participating providers provide access to medical records, require identification of the ordering physician on laboratory, x-ray and prescription claims and provider education.

Fines were levied against one provider in both 1979 and 1980 and one assigned a jail term in 1979. Restitution and probation were levied against one provider in 1979 and two in 1980. For clients, one was fined in 1979, and one received a jail term in both 1979 and 1980. Restitution and probation were levied against seven clients in 1979 and ten in 1980. A MMIS was implemented in 1978 and bulk purchasing of goods in 1980.

Total Medicaid expenditures increased from $161.799 million in 1978 to $196.283 million in 1980, with state outlays growing from $44.110 million, to $57.639 million, and federal expenditures from $117.689 million to $138.643 million. Proportionately, the state contributed 27.26%, 27.61% and 29.37% each year, while the federal government contributed 72.74%, 72.39% and 70.63% in the same three years. Medicaid enrollment increased from 247,583 in 1978 to 256,198 in 1980.

To control eligibility determination errors and costs in determinations, the performance of eligibility determination workers are monitored.

In 1978 the state implemented a program to recover Medicaid funds from health and casualty insurance and from absent parents. Funds are also recovered through federal financial participation in retroactive Mediciad eligibility determination.

Mandatory Medicaid funds for inpatient hospital services increased 29.3% from $5.703 million in 1978 to $7.378 million in 1980 and outpatient hospital services and rural health clinic funds by 53.36% from $564,580 in 1978 to $865,857 in 1980. SNF funds declined 23.1% from $3.395 million in 1978 to $2.758 million in 1980. Over the same period physician service funds increased from $3.020 million to $3.803 million or 25.93%, and EPSDT funds from $693,111 to $701,360 or 25.93%, Funding for optional programs also increased by 14.4% for medical and other remedial care from $247,259 in 1978 to $282,856 in 1980, drug funds from $1.424 million in 1978 to $1.857 million in 1980 or 30.4%, and for ICF care by 52.68% from $14.286 million in 1978 to $21.812 million in 1980.

A common Medicare and Medicaid audit was implemented by the state's hospital reimbursement system in 1968 and tape to tape billing in 1980. In 1968 the nursing home reimbursement system implemented the submission of a single invoice for all patients by the nursing homes. During 1976, rate ceilings were established, as well as reimbursement according to peer grouping. Limits were set by cost centers and the reimbursement rate indexed to economic trend factors.

Physicians services are reimbursed based on the usual, customary and reasonabe charges. Reimbursement is based on the 75th percentile of the 1975 UCR charges. Payment of physicians at the rate for a service when it was delivered, not billed, has been proposed.

Both nurse practitioners and physician assistants are reimbursed indirectly by the Medicaid program at the same rate as the physician office reimbursement rate.

During Fiscal Year 1981 a Medicaid Management Information System will be implemented.

Total Medicaid expenditures increased from $36.150 million in 1978 to $53.014 million in 1980. The state's contribution increased from $11.263 million in 1978 to $13.681 million in 1980 or 21.47%, while the Federal share rose 58% from $24.887 million in 1978 to $39.334 million in 1980. Proportionately, the federal share each year was 68.85%, 70.89% and 74.19% while the state's share amounted to 31.15%, 29.11% and 25.81% in 1978, 1979 and 1980 respectively. Total Medicaid enrollment, however, decined from 34,654 in 1978 to 32,215 in 1980. Average per day hospital room reimbursement rates rose from $112.93 in 1978 to $137.41 in 1980, an increase of 21.68%. The average non-specialist physician rate per office visit was $7.00 in 1978 and remained at $8.00 in 1979 and 1980. SNF average rates rose 21.2% from $19.1 in 1978 to $23.15 in 1980; ICF average rates also rose 24.74% from $16.98 in 1978 to $21.18 in 1980.

For the categorically eligibles, several changes were made in Medicaid standards in June of 1980. These include: changes in resource limits for automobiles; change in handling cash value of life insurance; increase in allowable value for the homestead; change in treatment of income from legally responsible relative; and increases in the work expense allowance. The latter two changes are expected to contribute to a decrease and increase in enrollment, respectively. For the medically needy the standard was increased from $108 to $117 in 1978 with no noticeable change in enrollment. In August of 1980, the implementation of prospective retrospective spend-down quarters occurred, in addition to a change in the treatment of income and resources of legally responsible relatives of children in psychiatric clinics.

As of 1976, retrieval of Medicaid ID cards from ineligibles, training of eligibility determination workers and the monitoring of their performance were instituted to control administrative errors or costs in eligibility determinations. Error prone profiling and the consolidation of Welfare and Medicaid eligibility applications have been proposed. To reduce client errors, monitoring client income through linkages with other employment data files was implemented in 1976, provider verification of client identification was instituted in 1969, and provider telephone inquiries to the state as to eligibility status was adopted in 1980.

Since 1976, Tennessee has implemented a program to recover Medicaid funds from health and casualty insurance. Absent parents have also been proposed as a source of retrievable funds. Changes in Medicaid covered benefits in fiscal year 1981 are: restriction of the drug formulary; a possible limit on the number of prescriptions and refills; the adding of MAC to several additional drugs; and a limit on outpatient hospital visits to six per year. The estimated change in expenditures from the first three changes is expected to be $8.5 million and from the last change $3.0 million.

Mandatory hospital benefits generally increased between 1978 and 1980 in Tennessee. Inpatient hospital services rose from $59.700 million in 1978 to $80.243 million in 1980, an increase of 34.4 percent. Spending for outpatient hospital services and rural health clinics rose from $10.283 to $13.403 million, physician services from $27.747 million to $30.972 million; and SNF care from $2.841 million to $5.984 million. Early and periodic screening and diagnostic testing expenditures increased from $4.146 million to $5.510 million. Lab and x-ray funds increased from $350,600 in 1978 to $1.347 million in 1980, an increase of 285 percent. Family planning funds grew from $706,600 to $756,700 and then declined to $688,500; and optometrist funds rose from $398,500 in 1978 to $436,400 in 1980.

Optional benefits for home health care rose dramatically from $586,300 in 1978 to $1.149 million in 1980. Clinic services grew from $4.029 million in 1978 to $7.348 million in 1980, ten mental health clinics received $2.706 million in 1978 and $5.155 million in 1980. Funds for dental services declined from $251,700 in 1978 to $243,700 in 1979 before rising to $250,000 in 1980. The largest optional expenditures

were for drug funds and ICF care, drug funds rising from $30.143 million to $38.481 million, and ICF funds from $107.396 million to $156.000 million. Institutions for mental diseases for those sixty-five and older received $21,300 in 1978 and $34,800 in 1980, while psychiatric hospitalization for those under twenty-one received $368,200 in 1978 and $4.490 million in 1980.

Tennessee's hospital reimbursement system implemented denial of reimbursement for percentage contracts for laboratory and x-ray services in 1969, limited laboratory service reimbursement to a high volume, established on automated lab rate, and proposed the disallowance of weekend admission reimbursement for non-emergency service. Hospitals are reimbursed on the basis of Medicare reasonable costs. Since 1969, they have been paid on an interim basis and common Medicare and Medicaid audits were implemented. A limit was placed on the age of claims in 1979. The nursing home reimbursement system placed a cap on administrative salaries for owners and relatives only in 1968, and in 1973 established rate ceilings and began indexing reimbursement rates to to economic trend factors. In 1974, limiting pass-throughs was made a mandatory requirement; identical treatment of leased or owned facilities began in 1976, and submission of a single invoice by the nursing home for all patients was implemented in 1978.

Physicians are reimbursed on the basis of the usual, customary and reasonable charge which is updated every 1-2 years; for example, the 1976 profile was updated to the 1978 profile in September of 1979. In the update, accumulated Medicaid data are used and compared with the Medicare usual and customary data. It has been proposed to reimburse physicians at the rate for service when it was delivered, not billed, and to change the percentile of charges from the 90th percentile to the 70th.

Three changes have been proposed for the Medicaid reimbursement rate in Fiscal Year 1981. For physicians, dentists and labs, the proposal is a reduction in payment from 90 percent to 70 perent of the 75th percentile of the 1978 profile with an expected change in expenditures of $9.0 million. For hospitals, it is proposed that payment not exceed the 75th percentile; and lastly, for SNFs and ICFs, the proposal would set the maximum rate at 50 percent of facilities instead of beds.

While Tennessee has no formal state plan for monitoring PSRO utilization reviews, the state does use SUR of the MMIS (Medicaid Management Information System) to identify LOS which are excessive and questionable admissions. The MMIS was implemented in 1979. Prior authorization is required for certain medical and dental procedures and has been required from the beginning of the program. In 1978, preadmission review for admission to nursing homes was made mandatory.

In 1969 utilization control measures, such as the disallowance of claims and the requirement that participating providers give access to medical records, were made mandatory. Other control measures which have been implemented include required identification of the ordering physician on laboratory, x-ray and prescription claims and a lock in of high users to one physician and one pharmacist.

Total Medicaid expenditures grew from $257.733 million in 1978 to $363.153 million in 1980. The state's contribution increased from

$79.297 million to $111.522 million, and the federal government's contribution from $178.436 million to $251.632 million. Proportionately, the state's share of the total was 30.77%, 31.04% and 30.71% in each of the three years, while the federal government's share was 69.23% 68.96% and 69.29%. Total Medicaid enrollment declined from 431,565 in 1978 to 422,151 in 1979 and then increased to 431,000 in 1980. The number of categorical eligibles enrolled rose from 320,102 to 358,681 to 365,000, while the medically needy enrollment declined from 111,463 to 63,470 and then increased to 66,000. From 1978 to 1980 the average provider reimbursement rates for a hospital room increased from $147.63 to $173.38. From 1978 to 1979, the average non-specialist physician rate per office visit rose from $16.65 to $17.90, SNF rates from $27.53 to $31.89, and ICF rates from $21.85 to $23.69. The home health visit rate rose from $26.45 in 1978 to $28.89 in 1979 but declined 28 cents to $28.61 in 1980.

For the categorically needy the medical assistance income limit was raised from $395 to $568.20 with gross income counted, with an increase in enrollment of 2,752 in Fiscal Year 1979. During 1979, the state ceased counting resources of an ineligible spouse not residing with the client, increased SSI payment standards, sustained MAO income cap of $560.20, added SSI exclusions for Medical Assistance Only (MAO) eligibility determination and increased the amount of the automobile exclusion. The 1980 changes include: expanding of MAO elgibility for certain long term care recipients to include non-institutional living arrangement; permitting adding exclusion of patient income transferred to children applying for SSI related MAO; and, excluding VA aid and attendance benefits in SSI related MAO eligibility determination; one proposed change not yet implemented is the provision of alternate care service to the aged, blind, and disabled who would be eligible for nursing home care.

To control administrative errors and cost in eligiblity determination Medicaid and Welfare eligibility applications were consolidated and training of eligibility determination workers and monitoring of their performance instituted in 1967. To minimize client errors, provider cerification of client identification was instituted in 1967, monitoring clients RSOI with Bendix was implemented in 1973, and monitoring of client income through linkages with other employment data files in 1974. A requirement for reporting chages was adopted in 1978. Provider telephone inquiries to the state as to eligibility status and photo ID have both been proposed.

Although some recovery system existed prior to 1979, that year represents the start of a more comprehensive effort to recover Medicaid funds from absent parents, the Veteran's Administration, casualty and health insurance and through federal financial participation in retroactive Medicaid eligibility determination. Other means of recovery has been through probate and tort feasor.

Medicaid covered services in July 1978 were changed to include rural health clinic services, and in January 1978 a limited adult denture program to eligible individuals who requested benefits on or before Novmeber 25, 1978. During Fiscal Year 1979 a payment limitation on blood or packed blood cells was removed, ICF services provided in Christian Science Sanitoriums were added, limited occupational therapy provided and outpatient hospital service to medically oriented OT services provided. In addition, personal care services were added as a covered service, adult day health services added as a benefit, and the amount of personal care services authorized increased from 15 to 20 hours per week.

All mandatory expenditures declined in one year or another between 1978 and 1980. Inpatient hospital services rose from $135.886 million in 1978 to $143.224 million in 1979, but declined to $107.513 million in 1980. Outpatient hospital services and rural health program resources declined from $15.570 million in 1978 to $11.886 million in 1980. Funding for lab and x-rays, SNF care and physician services displayed the same pattern, with lab and x-ray declining from $925,299 in 1978 to $851,468 in 1980 and SNF from $30.606 million to $27.385 million. Physician

service funds declined by 26.1% from $83.367 million in 1978 to $66.125 million in 1980. EPSDT declined each year from $2.684 million in 1978 to $2.582 million in 1979 to $1.564 million in 1980. Optical service increased from $2.014 million to $3.683 million.

Optional expenditures for medical or other remedial care remained at $3.857 million in 1978 and 1979, but declined to $227,186 in 1980. Home health funds grew from $800,093 in 1978 to $1.037 million in 1979, while the EPSDT dental program declined slightly from $10.49 million to $10.424 million over the same period. Funds for drugs and dentures both increased over the same period from $52.289 million to $58.536 million and from $3.302 million to $8.344 million, respectively. ICF funding for the elderly grew from $307.989 million in 1978 to $353.322 million in 1979 but declined to $256.653 million in 1980. ICF for the mentally retarded rose from $79.202 million in 1978 to $127.915 million in 1979 to $101.6 million in 1980.

A limit was placed on the age of claims in 1967 and tape to tape billing implemented in 1979 by the state hospital reimbursement system.

All hospitals are paid by the system on an interim basis as of 1967, and caps placed on administrative salaries as of 1977. The nursing home reimbursement system also adopted several measures, beginning in 1972 with reimbursement according to peer grouping, typing reimbursement rates to grades of patient disability, and submission of a single invoice by the nursing home for all patients. All other changes were made in 1977 including the establishment of rate ceilings, limiting capital costs, elimination of efficiency incentives for certain types of facilities, setting limits by costs centers, indexing the reimbursement rate to economic trend factors, and capping administrative salaries.

Physician services are reimbursed on the basis of usual, customary and reasonable charges. These charges are based 100% on Medicare and are updated annually. As of 1967 reimbursement has been at the rate for service when it delivered, not billed and at the rate for service where it was delivered, not from where service is billed.

During 1979, three changes were made in the categorical eligibility standards, beginning with elimination of coverage for persons aged 18 to 21 years. This change affected approximately 400 to 500 persons. The other changes were the cessation of income attribution for an institutionalized spouse and the necessity to pay excess medical for all months of the retroactive period. These last two changes are expected to have a very negligible effect on enrollment. For the medically needy, changes included the necessity to count in kind income for the adult category.

Medicaid expenditures for mandatory benefits increased for inpatient hospital services from $12.116 million in 1978 to $17.548 in 1980. Funds for outpatient hospital services and rural health clinics increased from $1.7 million in 1978 to $1.806 million in 1980, and lab and x-ray to 1980, from $121,420 to $304,847. SNF expenditures remained stable at about $10.1 million in this period, while physician services rose from $3.740 million to $4.750 million. Funds for early and periodic screening and diagnostic testing grew from $100,587 in 1978 to $205,000 in 1980 and spending for optometrists funds declined from $446,203 in 1978 to $143,000 in 1980.

Expenditures for optional benefits such as medical or other remedial care rose from $3.946 million in 1978 to $4.689 million in 1980, or by 18.83 percent, and for home health care by 38.54 percent from $100,336 to $139,000. Funds for general clinic services declined from $1.854 million to $1.706 million and expenditures for mental health clinic services grew 34.29 percent from $250,606 to $336,530 between 1978 and 1980. Dental service funds declined from $2.558 million in 1978 to $1.159 million in 1980. Drug funds, however, increased 16.89 percent from $3.357 million, to $3.924 million as did funds for physical, occupational and speech therapy which grew from $215,144 to $357,479 over the same period. Other optional benefits which also increased are ICF, from $25.908 million to $40.245 million, psychiatric hospitalization for those under 21, from $554,077 to $1.150 million, and institutionalization for mental diseases for those 65 and older, from $455,458 to $519,989.

All hospitals are paid on an interim basis by the state's hospital reimbursement system which has also instituted common Medicare and Medicaid audits. The nursing home reimbursement system has also adopted several measures beginning in 1970 by tying reimbursement rates to grades of patient diability and submission of single invoices by nursing homes for all patients. In 1976, the profit factor was eliminated from the reimbursement rate, the reimbursement rate was indexed to economic trend factors, caps were placed on administrative salaries and, beginning in 1978, leased and owned facilities were treated identically. Four measures were implemented in 1979: establishment of rate ceilings; reimbursement according to peer grouping; limits on capital costs; and setting limits by cost centers. As of 1975 Utah has implemented a Medicaid Management Information System.

For both the categorically eligible and the medically needy, protected income levels were increased to adjust for the cost of living during 1978, 1979 and 1980. To control administrative errors and costs in eligibility determinations, and to reduce client errors, the state began training eligibility determination workers and monitoring their performance in 1966. Provider telephone inquiries to the state as to determine eligibility status also was instituted. In 1975, the state began issuing monthly ID cards. In 1976 monthly client status reports were required and in 1978 monitoring of client income through linkages with other employment data files was implemented.

To retrieve Medicaid funds, the state implemented several programs to recover funds from casualty insurance in 1972, absent parents in 1978, and the Veteran's Administration and health insurance in 1979. Medicaid covered services were extended to eye vision services to eligibiles over twenty-one years in Fiscal Year 1980 at an estimated cost of $60,000 annually.

In Vermont, expenditures for mandatory benefits largely increased from 1978 to 1980. Funds for inpatient hospital services increased 20.9 percent from $8.502 million in 1978 to $10.280 million in 1980, and for outpatient hospital services and rural health clinics from $1.475 million to $1.848 million or by 25.3 percent. Expenditures for lab and x-ray grew slightly from $545,108 in 1978 to $581,122 in 1980. Over the same period, SNF funds grew from $942,728 in 1978 to $1.084 million in 1980, physician services from $5.327 million to $6.601 million, and early and periodic screening and diagnositic testing from $247,870 to $358,361. Family planning and optometrist services increased by 12.1 percent and 26.8 percent respectively, from $354,982 to $398,004 and $76,518 to $97,024.

Expenditures for optional benefits all increased from 1978 to 1980 with home health care rising 43.9 percent from $633,368 to $911,475, mental health clinics from $2.024 million to $2.698 million, and dental service from $858,965 to $972,729. The largest optional expenditure categories also saw an increase with drug funds rising from $2.825 million to $3.238 million, ICF care from $15.250 million to $17.664 million, and psychiatric hospitalization for those under 21 from $2.997 million to $4.103 million.

Hospitals are reimbursed on the basis of Medicare reasonable costs and are paid on an interim basis as of 1966. In 1980 common Medicare and Medicaid audits were instituted, as well as tape to tape billing in 1978. A limit was placed on the age of claims beginning in 1972. The nursing home reimbursement system also adopted several measures in 1975 including the elimination of the profit factor in the reimbursement rate, a limit on pass-throughs, caps on administrative salaries and identical treatment of leased and owned facilities. A limit was placed on capital costs in 1979.

Physicians in Vermont are reimbursed using either a fee schedule or the usual, customary and reasonable charge, whichever is lowest. The

usual, customary and reasonable charge is based on the 1978 Medicare profiles and specialty prevailing rates. In reimbursing physicans a limit has been placed on the number of billable procedures and reimbursement is at the rate for service when it was delivered, not billed and at the rate where service was delivered, not from where service is billed. Physician assistants are reimbursed indirectly by Medicaid. The reimbursement rate is based on the individual practitioner profile.

The state plan for monitoring PSRO utilization review activities monitors inpatient hospital use by comparing actual discharge rates for diagnostic and surgical groups by each hospital against expected discharge rates. When actual rates exceed the expected rates by a significant degree, the PSRO is asked to examine the situation and take corrective action if necessary. Nursing home care is monitored by reviewing a sample of PSRO admission and continued stay decisions. When there are disagreements between state monitoring and PSRO results they have been resolved by meeting with the PSRO. If that method does not work, assistance is sought from the DHEW regional office. All nursing home care and selected surgical procedures are prior authorized to determine medical necessity as are hospital admissions for dental surgery.

Several measures aimed at controlling utilization have been implemented beginning in 1966 with provider education and the provision of access to medical records by participating providers. Measures that were implemented in 1978 include monitoring hospital discharge planning units, disallowance of claims, limitation on length of stay for stays without PSRO approval, changing average or reimbursement rate for administrative days, requiring identification of the ordering physician on laboratory, x-ray and prescription claims, and lock in of high users to one physician. Patient education was adopted on a demonstration basis in 1980.

Excess payments were recovered from 20 providers in 1979 and from 50 in 1980, and as of 1966, Medicaid has been contracting out for claims processing and in 1978 implemented a Medicaid Management Information System.

Total Medicaid expenditures increased from $45.703 million in 1978 and to $56.659 million in 1980. The state outlay grew from $14.616 million to $17,904 million, and the federal outlay from $31.085 million to $38.754 million. The state proportion of total Medicaid spent in 1978 was 31.98 percent and the federal share 68.02 percent. In both 1979 and 1980 the proportionate share was 31.6 percent from the state and 68.4 percent from the federal government. Medicaid enrollment also increased from 49,075 in 1978 to 50,784 in 1980. The categorical eligibles enrolled grew from 46,546 to 48,143 and the medically needy from 2,527 to 2,641. Reimbursement rates increased in several areas: daily hospital room rates rose from $104 in 1978 to $116 in 1980; average non-specialist physician rates per office visit from $8.25 to $9.36; average daily SNF rates from $26.70 to 35.00; average daily ICF rate from $22.38 to $27.50; and average home health visit rate from 26.00 to 27.00.

VIRGINIA

Virginia's categorically eligible Medicaid program was revised several times in 1978. Protected eligibility for SSI and Medicaid recipients, whose SSA cost of living increase received after April 1977, resulted in termination of SSI and the exclusion of presumptively blind or disabled SSI recipients. In 1980 residency definition was changed to conform with 1979 federal regulations. For the medically needy numerous changes were made in 1978, including an increase in the income level, an addition to the income disregard-specified CETA income, and termination of the exclusion of children between eighteen and twenty-one years not in school and earning over $600 annually from the ADC category. Additional changes in Mediciad eligibility policy in 1978 are the inclusion of over the counter drugs and medical supplies prescribed by a physician in the list of spend-down items, and a liberalizing change in the method of computing responsible expected contribution. During 1979 the changes included: no longer excluding a child from Medicaid due to removal of the child from ADC because of WIN or Social Security number requirements; expansion of the groups of children covered under the foster care category; an increase in income levels (group II localities only); the possiblity of excluding a child from the family unit who has his/her own resources; a minimum income of $1,000 annually before a child can be excluded; a change in the definition of separation of couples due to a federal count decision; and, the exclusion of cemetary plots in the consideration of assets. Changes in 1980 include: a revised definition of deprivation; the use of equity value of real and personal property to determine resource eligibility; a change in the resource computation method for checking account; one month's income being deducted from amount in account; increase in ADC related earned income disregards; medical expenses of ineligible dependent spouse allowed toward eligible spouse's spend-down; increase in the food allowance of boarders; and increase income levels for families of five or more. No change has been made in Medicaid covered services as of June 30, 1978.

To control administrative costs and errors in eligibility determinations, the state adopted Bendex and SDX in 1974, retrieval of Medicaid ID cards from ineligibles and training of eligibility determination workers in 1970, training modules for eligibility workers, monitoring of their performance, and one month valid ID cards in 1978. Welfare and Medicaid eligibility applications were consolidated in 1979. To reduce client errors provider telephone inquiries to the state as to eligibility status was implemented in 1970, and monitoring of client income through linkages with other employment data files beginning in 1978. Monthly client status reports have also been proposed. As of 1970 Virginia implemented a program to recover Medicaid funds from health and casualty insurance and is proposing to recover funds from absent parents.

Mandatory benefits for inpatient hospital services increased from $61.809 million in 1978 to $84.651 million in 1980, an increase of 36.90%. Outpatient hospital services and rural health clinic funds rose from $15.765 million to $18.039 million to $20.140 million each year for a 1978-1980 increase of 27.76%. From 1978 to 1980 funds for SNF and EPSDT also increased, from $7.361 million to $10.713 million

and $519.000 to $653.00, respectively. Lab and x-ray funds rose from $150.00 in 1978 to $3.124 million in 1979 but declined to $970.00 in 1980 for an overall increase of 547%. Physician services also declined from $27.368 million in 1978 to $27.193 million in 1979 but increased to $31.514 million in 1980. Family planning funds declined from $1.261 million in 1978 to $1.062 million in 1979 and increased to $1.353 million in 1980 for a 7.3% increase from 1978 to 1980. Funds for other physicians rose 26.1% from $1.565 million in 1978 to 1.973 million in 1980.

Optional benefit expenditures, such as home health care rose from $938,000 in 1978 to $1.211 million in 1979 before declining to $1.003 million in 1980. Clinic service funds rose from $1.869 million in 1978 to $2.306 million in 1979 and then declined to $2.055 million in 1980. From 1978 to 1980 dental funds increased 20.1% from $4.067 million to $4.885 million, drug funds by 35.56% from 17.446 million to $23.650 million and ICF funds by 69.86% from $116.046 million to $197.114 million. Funding for institutions for mental diseases for those sixty-five years and older rose from $7.214 million in 1978 to $8.272 million in 1979 but declined to $6.714 million in 1980. Optional expenditures for these programs rose from $3.435 million in 1978 to $5.137 million in 1980.

In 1975 the hospital reimbursement system limited the maximum length of stay to twenty-one days and placed a limit on the age of claims. The system pays all hospitals on an interim basis as of 1969 and is proposing to implement common Medicare and Medicaid audits as soon as possible. Denial of reimbursement for 8.5% nursing cost differential was also implemented in 1969. The nursing home reimbursement system began treating leased and owned facilities in an identical manner and imputing a useful lifetime of fifty years on nursing home facilities as of 1969. Rate ceilings were established in 1972 and revised in 1978, caps placed on administrative salaries in 1976, and a limit placed on capital cost in 1978, in addition to the indexing of reimbursement rate to economic trend factors.

Physician services are reimbursed on the basis of usual, customary and reasonable charge based on Medicare data; however, the ceiling has not been changed. During 1978 a prospective payment system for nursing homes was implemented.

In the state plan for monitoring PSRO utilization review activities, three reports are generated on a quarterly cycle: A) a LOS (length of stay) Exception Report which contains a listing of all claims indicating a live discharge and which except the LOS parameter; B) a Hospital Summary Report which summarize data from the LOS report. Claims are by diagnosis code within providers within the PSRO area and the exceptions are identified as a percentage of the total claim; and, C) the PSRO Summary Report is a further summary by provider within the PSRO area. The providers are ranked in descending order by the the number of their LOS exceptions. Impartial professional assistance is sought in settling disagreements between state monitoring and PSRO results. Within the thirty day response period, the state and the PSRO may, at their option, arrange for a group of knowledgeable physicians, acceptable to both parties, to review the questioned determinations and the basis utilized in arriving at that determination.

Beginning in 1969 utilization controls were adopted to require participating providers to give access to medical records and in 1975 a limit placed on the length of stay for stays without PSRO approval. As of 1978 the identification of the ordering physician has been required on laboratory, x-ray and prescription claims. In 1979 one provider was removed from the Medicaid program and fined. Beginning in 1969 Medicaid contracted out to a fiscal agent and in 1977 a MMIS was implemented.

Total Medicaid expenditures increased from $272.873 million in 1978 to $398.870 million in 1980. During this period, the state's share rose from $118.531 million to $173.349 million, an increase of 46.25%, and the federal outlays by 46.1%. Proportionately, the state's share of the total each year was 43.44%, 42.14% and 43.46% while the federal government's share totaled 56.56%, 57.86% and 56.54%. Total Medicaid enrollment also increased from 363,229 to 387,000 an increase of 6.54%. From 1978 to 1980 the categorically eligible enrollment climbed from 304,477 to 324,000 and the medically needy from 58,752 to 63,000. The average reimbursement rate per day for a hospital room also rose 12.58% from $159.6 in 1978 to $179.67 in 1980, while average non-specialist physician rate per office rate rose slightly from $13.23 to $14.00. From 1978 to 1980, the average SNF rate rose 8.56% from $38.69 to $42.0, and the average ICF rates by 38.95% from $24.83 to $34.50.

As of June 1978, there have been no changes in the Medicaid categorical or medically needy eligibility requirements. However, a spend-down requirement has been proposed for the medically needy and its impact on eligibility and enrollmentis is as yet unknown.

Several measures to control administrative errors or costs in eligibility determinations have been implemented and proposed. In 1969, the training of eligibility determination workers and monitoring of their performance was instituted. Error prone profiling has also been proposed. Measures to reduce client errors were implemented in 1967, including monitoring of client income through linkages with other employment data files, monthly client status reports, and provider telephone inquiries to the state to determine eligibility status. Requiring the personal pickup of checks in limited occasions is another measure that has been adopted.

To recover Medicaid funds, programs were established in 1956 to retrieve funds from absent parents, in 1969 from the Veteran's Administration, health and casualty insurance, and in 1966 from federal financial participation recovery through retroactive Medicaid eligibility determination.

Mandatory Medicaid benefits for inpatient hospital services reached $68.131 million in 1978, $76.576 million in 1979, and $85.126 million in 1980. This represents an increase of 12.40 percent from 1978 to 1979, and 11.17 percent from 1979 and 1980. Funds for outpatient hospital services and rural health clinics rose from $9.142 million in 1978 to $13.172 million in 1980, an increase of 44.1 percent. Other services increased at varying rates from 1978 to 1979: lab and x-ray rose from $1.042 million to $1.455 million; SNF from $83.151 million to $120.225 million; physician services from $35.242 to $40.582; early and periodic screening and diagnostic testing from $919,000 to $1.085 million; family planning from $2.039 million to $2.112 million; and optometrists from $1.298 million to $2.078 million.

Funds for all opitional benfits grew from 1978 to 1980. Medical or other remdial care increased w 46.1 percent from $11.723 million to $17.122 million and home health care from $961.000 to $1.801 million or 87.41 percent. Drug and dental care expenditures also increased by 19.11 percent and 17.11 percent, respectively, or from $14.291 million to $17.022 million and $13.081 million to $15.245 million. The only optional benfit which declined was private duty nursing from a high of $33,000 in 1978 to $2,000 in 1980.

Limitating laboratory service reimbursement to a high volume, automated lab rate (rather than reimbursing all labs, large and small, for actival costs increased) has been proposed, as an addition to the state's hospital reimbursement system. In 1974, the disallowance of weekend admission reimbursement for nonemergency services was instituted. A prudent buyer program has been proposed.

Reimbursement of hospitals in Wahsington is accomplished under the Washington State Hospital Commission Prospective Reimbursement Demonstration Project. Phase II of this project will replace Medicare reasonable cost basis for all hospitals in the state. As of 1972 common Medicare and Medicaid audits have conducted, and in 1977 tape to tape billing was instituted. Limiting the age of claims and reimbursements on an interim basis, have always been the policy in Washington. Measures adopted by the nursing home reimbursement system in 1974 include establishment of rate ceilings, submission of single invoices by nursing homes for all patients, setting limits by cost centers, caps on administrative salaries and imputing a useful life time of 40 yeras to nursing home facilities. In 1975, indexing the reimbursement rate to economic trend factors was instituted; limits on capital costs and tying of reimbursement rates to grades of patient disability were adopted in 1978. Other measures include use of a regression equation to establish property cost center lid limits, and subsequent rate payments which limit the amount the state will pay for assets. The state also was an imputed useful lifetime for facilities of 30 years.

Physician services are reimbursed on the basis of a fee schedule and reimbursement is at the rate for service when it was delivered, not billed, and at the rate where service was delivered, not for where service is billed. In 1971 the number of billable procedures was limited. The Washington Medicaid program has proposed a per capita payment for each recipient accepted by physicians, although the program has not yet been approved at the federal level. Washington has agreements with HMOs paid on a per capita basis, and has proposed to adopt Medicare rates or a percentage thereof.

As of July 1980, the Medicaid rate for Home Health Agencies is based on the previous year's cost, with an expected increase in expenditures of $675,000. New fees and use of the CPT-4 were instituted in January 1980 in a schedule of maximum allowances. The office visit reimbursement rate for nurse practitioner rose from $6.40 to $6.77 in 1979, and to $7.14 in 1980. For physician assistants, the rate is 10 percent of the amount billed up to the maximum.

Washington is currently developing a plan for monitoring the utilization review conducted by PSROs. The plan, however, has not received final approval by the federal government. The following utilization controls have been incorporated into the program since its inception: monitoring hospital discharge planning units, disallowance of claims, and limitation on length of stays without PSRO approval. In Fiscal Year 1980, lock in of high users to one physician and a requirement that participating providers provide access to medical records were implemented; outpatient and provider education will be implemented in 1981.

In 1979, the following sanctions were imposed: 3 providers were suspended from the Medicaid program and 1 in 1980; 1 was removed from the program in 1979 and 4 in 1980; 4 were fined in 1979 and 3 in 1980; 2 were assigned jail terms in both years. Six clients were locked in during 1980.

The average number of Medicaid enrollment in prepaid group practices was 8,298, 6,590 and 6,607 in 1978, 1979 and 1980, respectively. Since about 1970, Medicaid has purchased goods in bulk, including eyeglasses and oxygen. In 1976, a Medicaid Management Information System was implemented. Contracting out for respiratory therapy and dental services has also been instituted. Other administrative changes involve HMO contracts to Group Health in 1972, Kaiser in 1974, and Cooperative Health Plan in 1979.

Medicaid expenditures in 1978 were $240.6 million, $289.4 million in 1979 and $333.0 million in 1980. State contributions increased from $114.5 million to $164 million, while the federal share increased from $126.1 million $169 million in the three years. The state contribution to the 1978 Medicaid total was 47.59 percent, while the federal share was 52.41 percent, compared to 49.25 percent and 50.75 percent, respectively, in 1980. Total Medicaid enrollment increased from 253,900 in 1979 to 261,000 in 1980, with categorical eligibles rising from 233,000 to 236,000 and medically needy from 20,900 to 25,000. NonMedicaid state general assistance for medical care was $16.8 million in 1978 and $26.5 million in 1980; hospital admissions also rose from 61,930 to 70,915 from 1978 to 1980, while SNF and ICF admissions decreased from 24,446 to 22,547. The number of home health patients grew from 2,474 in 1978 to 3,106 in 1980. The average per day hospital room reimbursement rate rose from $108.61 in 1978 to $127.33 in 1980, and the home health visit rate increased from $29.20 to $35.50. Physician rates per office visit increased slightly, from $13.41 to $14.67 over the same time period.

The only change in Medicaid eligibility standards was a proposed discontinuance of the medically needy component of Medicaid to have begun July 1, 1980. This action was stopped by a court injunction on July 3, 1980. Cancellation of the program would have affected an estimated 16,000 persons.

Measures to control administrative errors and costs in eligibility determination have been implemented by the state beginning with retrieval of Medicaid ID cards from ineligibles in 1967, and in 1975 consolidation of Welfare and Medicaid eligibility applications, training eligibility determination workers and monitoring their performance was adopte Error prone profiling was adopted in 1976. To reduce client errors monthly client status report have been required as of 1972, and monitoring of client income through linkages with other employment data files was started in 1974. As of 1978 a program to recover Medicaid funds from health and casualty insurance was instituted; recovery from absent parents has been proposed.

Proposed changes in Medicaid covered services have all been stopped by a court injunction. The proposals cover termination of the medically needy program at a savings of $11.7 million, the reduction of hospital days covered from 60 to 30, a savings of $0.6 million, and a copayment for drug charges with a saving of $0.5 million.

Mandatory Medicaid expenditures for inpatient hospital services, outpatient hospital services and rural health clinics totaled $33.773 million in 1978, $37.443 million in 1979 and $46.671 million in 1980. SNF and ICF expenditures rose 10.9 percent from $23.562 million in 1978 to $26.123 million in 1979 and increased by 24.7 percent in 1980 to $32.561 million. Physician services also increased, from 1978 to 1980 from $10.210 million to $14.110 million, and optometrist services from $785,410 to $1.085 million. From 1978 to 1980, optional benefits for medical or other remedial care increased 38.2 percent and drugs increased 38.2 percent from $7.069 million to $9.768 million.

The state's hospital reimbursement system pays all hospitals on an interim basis and has instituted common Medicare and Medicaid audits and reimbursement on a hospital department basis. A limit was placed on the age of claims in 1967 and tape to tape billing has been proposed. In 1977 the nursing home reimbursement system adopted several measures including the elimination of the profit factor in the reimbursement rate for non-profit facilities, reimbursement according to peer grouping, a limit on capital costs, setting limits by cost centers, indexing the reimbursement rate to economic trend factors and identical treatment of leased and owned facilities. Caps were placed on administrative salaries in 1979.

Physician services are reimbursed on a fee schedule basis and in reimbursing physicians a limit has been placed on the number of billable procedures. Reimbursement is also at the rate for service when it was delivered, not billed. Both nurse practitioners and physician assistants

are reimbursed indirectly by the Medicaid program. West Virginia does not have an approved plan for monitoring PSRO utilization review activities. State monitoring is unofficial and informal.

In terms of prior review and authorization, a home health plan of care must be approved prior to payment and long term care patients must be precertified. Prior approval is required for remedial and restorative dental treatment and eye care except in an emergency, before durable medical equipment and supplies can be purchased. When West Virginia's Medicaid program was started in 1966, several utilization controls were adopted; these include disallowance of claims, limitation on length of stay for stays without PSRO approval, the requirement that participating providers provide access to medical records, and provider education. In 1976, coverage or reimbursement rate for administrative days was changed, high users were locked in to one physician, and, in 1980, the identification of the ordering physician was required on laboratory, x-ray and prescription claims.

During 1979 one provider was removed from the Medicaid program and one was suspended in 1980. No Medicaid recipients are enrolled in prepaid group practices in West Virginia. Three HMOs are under development in the state, but no deadlines have been established for the enrollment of Medicaid recipients. During 1980, the state implemented a Medicaid Management Information System and contracted out for a financial management contract for the equipment and computer system. Bulk purchasing of goods has also been proposed.

Total Medicaid expenditures rose from $78.541 million in 1978 to $108.537 million in 1980. In each year, the state contributed $25.737 million, $28.460 million and $36.803 million, an increase of 43.0 percent from 1978 to 1980. The federal contribution totaled $52.805 million, 58.616 million and $71.734 million from 1978 to 1980. The state's proportion in 1978, 1979 and 1980 was 32.77 percent, 32.68 percent and 33.91 percent and the federal government's share was 67.23 percent, 67.32 percent and 66.09 percent respectively.

WISCONSIN

On July 1 of each year the Medicaid categorical eligibility standards are increased and could cause a slight increase in the number of eligibiles. Since June 1978, only minor policy changes, having a ineligible effect on eligibility, have been instituted.

To control administrative errors and costs in eligibility determination, Wisconsin consolidated welfare and Medicaid eligibility applications in 1977. Training of elgibility determination workers has also been implemented and monitoring of their performance and error prone profiling have been proposed. To reduce client errors provider telephone inquiries to the state as to eligibility status has been proposed and in 1979 the monitoring of client income through linkages with other employment data files was implemented. Monthly client status reports have been implemented in some counties and a study of statewide application is now underway.

Beginning in 1968 the state implemented a program to retrieve Medicaid funds from casualty insurance and in 1978 from health insurance. A pilot program was started to retrieve funds from absent parents in August 1979; implementation of this program on a statewide basis has been proposed April 1981. The Wisconsin legislature has also proposed to render a recipient's estate liable to Medicaid fund retrieval.

Changes in Medicaid covered services as of February 1980 are: reductions/ limitations in reimbursement for psychotherapy services; addition of reimbursement for rural health clinics day treatment; outpatient alcoholism and other drug absue treatment services; restriction of podiatry service benefits to eliminate routine foot care; and, restrictions on personal care.

Mandatory expenditures for inpatient hospital services rose from $60.763 million in 1978 to $101.746 in 1980, an increase of 67.45 percent. Outpatient hospital service funds grew by 61.3 percent from $11.680 million in 1978 to $18.841 million in 1980, while lab and x-ray outlays declined from $2.025 million in 1978 to $603,000 in 1980. Funds for the following three programs increased each year: SNF from $114.404 in 1978 to $200.853 million in 1980; for early and periodic screening and diagnositc testing from $427.958 in 1978 to $1.613 million in 1980; and for optometrists from $1.695 million in 1978 to $5.291 million in 1980. Funds for physician services rose from $24.668 million in 1978 to $26.651 million in 1980, and family planning expenditures decreased from $2.435 million in 1978 tp $1.002 million in 1980.

From 1978 to 1980 optional expenditures for home health care and drugs both increased each year from $1.164 million to $2.938 million for home health, and from $24.333 million to $35.350 million for drugs. Funds for dental services grew from $14.013 million in 1978 to $16.492 in 1980. Physical, occupational and speech therapy spending declined from $6.768 million in 1978 to $2.290 million in 1980. ICF expenditures increased from $92.307 million in 1978 to $148.387 million in 1980, an increase of 60.75%

The state's hospital reimbursement system limited laboratory service reimbursement to a high volume, automated lab rate in 1977, and has proposed imputing an occupany rate. In 1977 the system also implemented tape to tape billing and placed a limit on the age of claims. In 1978 the state instituted denial of reimbursement for 8.5% nursing cost differential. Common Medicare and Medicaid audits have also been implemented. The nursing home reimbursement system placed a limit on pass-throughs in 1966, tied reimbursement rates to grades of patient disability in 1969, set limits by cost centers and indexed reimbursement rates to economic trend factors in 1971. In 1978 submission of a single invoice by nursing home for all patients was implemented. A limit on capital costs have been proposed.

Physician fees are reimbursed on the basis of usual, customary and reasonable charges. All physician fees are updated annually through the application of newly calculated Medicare profiles. A proposed, but not yet implemented, idea is to restrict the fee maximums charged by urban areas and physician specialists to that charged by the average Medicaid physician. As of 1977 a limit has been placed on the number of billable procedures; reimbursement is at rate where service was delivered, not from where service is billed and per capital payment for each recipient accepted by physicians implemented. In 1979 reimbursement at rate for service when it was delivered, not billed was implemented. In June 1980 Medicaid reimbursement for EPSDT was changed from cost reimbursement to flate rate, while physician assistants are reimbursed indirectly by Medicaid of 80% of the supervising physicians rate. A state plan to monitor PSRO utilization review activities is being developed.

Utilization controls which have been adopted include: monitoring of hospital discharge planning units, and disallowance of claims; requiring that participating providers provide access to medical records; mandating identification of the ordering physician on laboratory, x-ray and prescription claims; patient education; and, the lock in of high users to one physician. Changing coverage or the reimbursement rate for administrative days from hospital per diem to Medicare hospital based nursing care maximum (about $80) was rejected by the legislature in 1980, but may be proposed again in 1981. During 1979 three providers were removed from the Medicaid program, two were fined and two received jail terms, and in 1980 five were removed, three were fined and one received a jail term.

Medicaid enrollment in prepaid group practices reached 400 in 1978, 550 in 1979 and 631 in 1980. The current policy is to seek negoitiated contracts with all HMOs that can be contracted with under federal regulations. As new HMOs form or current HMO become federally qualified, contracts will be sought with them. Marketing efforts have been through mailings to AFDC clients in the HMO areas notifying them of the option to join and the advantages. County welfare staff have been trained in enrollment procedures and the advantages of HMO enrollment. The HMO's maintain continuing liason with county welfare offices and the county offices are requested to offer the HMO option to AFDC applicants.

A Medicaid Management Information System was implemented in 1977 and bulk purchasing has been proposed.

Total Medicaid expenditures rose from $418.728 million in 1978 to $696.469 million in 1980. State outlays increased by 67.3% from $175.050

million in 1978, to $292.873 million in 1980. Federal outlays grew from $243.679 million to $403.596 million, an increase of 65.63%, over the same period. Proportionately, the state's share each year was 41.81%, 41.75% and 42.05% and the federal government's share 58.19%, 58.25% and 57.95% in 1978, 1979 and 1980, respectively.

To control administrative errors or costs in eligibility determinations, the state consolidated Welfare and Medicaid eligibility applications in 1967. The state also began a program in 1967 to recover Medicaid funds from the Veteran's Adminstration, health and casualty insurance and through federal financial participation in retroactive Medicaid eligibility determination.

In Fiscal Year 1981, physical therapy service was added to Medicaid covered services at a cost of $50,000. Common Medicare and Medicaid audits were instituted in 1970 by the hospital reimbursement system. A limit was also placed on claims in 1967 and denial of reimbursement for 8.5 percent nursing cost differential implemented in 1972. The nursing home system adopted submission of a single invoice by nursing homes for all patients in 1971 and established rate ceilings in 1967.

Nurse practioners and physician's assistants are reimbursed by the Medicaid program indirectly at a rate equal to that for the supervising physician. Utilization controls adopted in 1967 include disallowance of claims and the requirement that participating providers provide access to medical records. The identification of the ordering physician has been required on laboratory, x-ray and prescription claims since 1970, and a limitition on the length of stay for stays without PSRO approval was adopted in 1973.

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